DEPARTMENT OF DEFENSE

Task Force on the

Future of Military Health Care

INTERIM REPORT

A SUBCOMMITTEE OF THE
DEFENSE HEALTH BOARD

DEPARTMENT OF DEFENSE

Task Force on the

Future of Military Health Care

INTERIM REPORT

A SUBCOMMITTEE OF THE
DEFENSE HEALTH BOARD

May 2007

Department of Defense
Task Force on the Future of Military Health Care

May 31, 2007

The Honorable Robert M. Gates
Secretary of Defense
The Pentagon
Washington, D.C. 20301

Dear Mr. Secretary:

The Task Force on the Future of Military Health Care is pleased to submit to you and to the Committees on the Armed Services of the Senate and House of Representatives the following interim report summarizing our work to date.

The Task Force was created to assess and recommend changes that would help sustain the military health care services being provided to members of the Armed Forces, retirees, and their families. With the mission specified in the John Warner National Defense Authorization Act for Fiscal Year 2007 (Section 711 of P.L. 109–364) as a constant guide, the Task Force presents this report of its preliminary findings.

The Task Force held public hearings, reviewed studies and research regarding program and organizational improvements to the military health care system, and visited military health care sites. As part of the public hearings, the Task Force also has heard extensive testimony related to cost-sharing under the pharmacy benefits program, which is a major focus of our interim findings and recommendations. While its research is by no means completed, the Task Force has laid a solid framework of areas to explore before filing its final report in December 2007.

In preparing the interim report, we were motivated by a belief that the members of our Armed Forces, their families, and military retirees, who have made and who continue to make enormous personal sacrifices in defending America, deserve a health care system that is flexible, effective, and cost-efficient. In summary, the system should provide much needed health care while considering fairness to the American taxpayer. The Task Force intends to issue a final report that is specific, compassionate, and practical in its recommendations. We are confident that the general findings in this interim report represent a strong start toward achieving our goal.

Sincerely,

Gail R. Wilensky, Ph.D.
Co-Chair

John D.W. Corley, General, USAF
Co-Chair

Department of Defense
Task Force on the Future of Military Health Care

May 31, 2007

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
228 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Ike Skelton
Chairman
Committee on Armed Services
U.S. House of Representatives
2120 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Levin and Chairman Skelton:

The Task Force on the Future of Military Health Care is pleased to submit to the Committees on the Armed Services of the Senate and House of Representatives, and to the Secretary of Defense, the following interim report summarizing our work to date.

The Task Force was created to assess and recommend changes that would help sustain the military health care services being provided to members of the Armed Forces, retirees, and their families. With the mission specified in the John Warner National Defense Authorization Act for Fiscal Year 2007 (Section 711 of P.L. 109–364) as a constant guide, the Task Force presents this report of its preliminary findings.

The Task Force has held public hearings, reviewed studies and research regarding program and organizational improvements to the military health care system, and visited military health care sites. As part of the public hearings, the Task Force also has heard extensive testimony related to cost-sharing under the pharmacy benefits program, which is a major focus of our interim findings and recommendations. While its research is by no means completed, the Task Force has laid a solid framework of areas to explore before filing its final report in December 2007.

In preparing the interim report, we were motivated by a belief that the members of our Armed Forces, their families, and military retirees, who have made and who continue to make enormous personal sacrifices in defending America, deserve a health care system that is flexible, effective, and cost-efficient. In summary, the system should provide much needed health care while considering fairness to the American taxpayer. The Task Force intends to issue a final report that is specific, compassionate, and practical in its recommendations. We are confident that the general findings in this interim report represent a strong start toward achieving our goal.

Sincerely,

Gail R. Wilensky, Ph.D.
Co-Chair

John D.W. Corley, General, USAF
Co-Chair

Department of Defense
Task Force on the Future of Military Health Care

General John D.W. Corley
USAF, Co-Chairman

Dr. Gail R. Wilensky
Co-Chairman

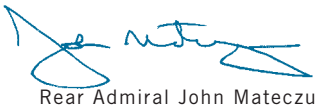
Nancy Adams
Major General, USA, Retired

Major General Joseph Kelley
USAF

Mr. Shay Assad

Mr. Lawrence Lewin

Dr. Carolyn M. Clancy



Rear Admiral John Mateczun
USN

Dr. Robert Galvin

Richard B. Myers
General, USAF, Retired

The Honorable Robert Hale

Lieutenant General James Roudebush
USAF

The Honorable Robert J. Henke

Robert W. Smith III
Major General, USA, Retired

Executive Summary

The provision of health services and health benefits is an established and significant mission of each military service branch. The world's largest military health care system serves several distinct classes of beneficiaries, including Active Duty military personnel, families of Active Duty personnel, reservists, and military retirees and their dependents. At the same time, unlike civilian health care systems, the Military Health System (MHS) must give priority to military readiness; the Nation's engagement in a long global war against terror; support of a conventional war if necessary; the provision of humanitarian relief and response to natural disasters; and the achievement of other missions required by national command authorities.

Given the current and likely future commitments of the military, it is critical to address several persistent challenges and the new challenges that are facing today's current MHS. These include rising costs, the expansion of benefits, the increased use of benefits by military retirees and the Reserve military components, continued health care inflation, and TRICARE premiums that have been level for nearly a decade. These challenges must be considered in the contexts of the current and ongoing needs of Active Duty military personnel and their families, the aging of the military retiree population, and the broader backdrop of the U.S. health care economy in which the military health care system operates. To sustain and improve military health care benefits for the long run, actions must be taken now to adjust the system in the most cost-effective ways.

Although improvements in internal efficiency will be critical to containing costs, and the rebalancing of government and beneficiary cost shares is being explored, such measures will be insufficient to stem the tide of rising health care costs, although they may help to slow their rate of growth.

Congressional concerns about the rising costs of the military health mission were reflected in Section 711 of the National Defense Authorization Act for Fiscal Year 2007, which established the Task Force on the Future of Military Health Care to make recommendations to Congress on a broad range of military health care issues. The authorizing language that established the Task Force stipulated that it submit an interim report on its activities to the Secretary of Defense and the Committees on Armed Services of the Senate and the House of Representatives. Specifically, the charge requires that the Task Force provide in this report its interim findings and recommendations regarding:

> (H) The beneficiary and Government cost-sharing structure required to sustain military health benefits over the long term… particularly with regard to cost-sharing under the pharmacy benefits program. (See Appendix B for the complete charge.)

Thus, this interim report focuses primarily on presenting preliminary findings and recommendations related to providing a pharmacy benefit that is cost-effective and that promotes accountability by all parties, including beneficiaries. In addition, it addresses other cost-sharing approaches and efficiencies with regard to the entire MHS.

Guiding Principles

As its beginning step, the Task Force debated and adopted a set of guiding principles to use in assessing the desirability of recommended changes. The Task Force first adopted an overarching principle:

> **All recommended changes must focus on the health and well-being of beneficiaries and be cost-effective, taking into account both short- and long-term budgetary costs as well as the effects on the specific guiding principles noted below.**

The Task Force then adopted six specific guiding principles. These principles require that the changes recommended by the Task Force, when taken as a whole, must:

1) **maintain or improve the health readiness of U.S. military forces and preserve the capability of military medical personnel to provide operational health care globally;**
2) **maintain or improve the quality of care provided to beneficiaries, taking into account health outcomes as well as access to and productivity of care;**
3) **result in improvements in the efficiency of military health care by, among other approaches, reflecting best health care practices in the private sector and internationally;**
4) **avoid any significant adverse effects on the ability of the military compensation system, including health benefits, to attract and retain the personnel needed to carry out the military mission effectively;**
5) **balance the need to maintain generous health care benefits in recognition of the demanding service rendered by military personnel to their country with the need to set and maintain a fair and reasonable cost-sharing arrangement between beneficiaries and the Department of Defense (DoD); and**
6) **align beneficiary cost-sharing measures to address fairness to taxpayers by promoting measures that enhance accountability and the judicious use of resources.**

Preliminary Findings and Recommendations

Based on its deliberations thus far, the Task Force offers the following preliminary findings and recommendations relative to DoD health care costs in general and to cost-sharing and the pharmacy program in particular. These recommendations are designed to achieve greater efficiencies and cost savings while continuing to ensure quality health care and maintain readiness to provide health care services during war. Recommendations are offered in the following areas: improving business and management practices; altering incentives in the pharmacy benefit; cost-sharing and realignment of fee structures; and ensuring that, when applicable, TRICARE is the second payer.

Improving Business and Management Practices

The Task Force has begun to examine best practices in the public and private health care sectors that produce efficiencies, including improved financial controls and procurement practices and heightened awareness and greater use of mail order pharmacy services. In undertaking changes in practice or policy, pilot studies and/or demonstration projects should be used to assess the feasibility and cost-effectiveness of new ideas. These studies and projects can be accomplished more quickly than systemic changes that probably will require statutory changes.

1. Review the DoD Pharmacy Contract Process

Findings:

Current practices in the DoD pharmacy procurement process appear to pose obstacles to negotiating both best price and best use. Additionally, some have interpreted legal provisions governing beneficiary contact as prohibiting multiple targeted programs to increase home delivery that have been used successfully in the private sector.

Recommendation:

1.1 DoD should review its pharmacy acquisition strategies to determine if changes can be made to effect greater reductions in the cost of drugs and to foster improvements in effective utilization. In doing so, DoD should consider pursuing policy, regulatory, and/or statutory changes that would allow for alternative commercial best practices to be implemented when in the best interests of the government.

2. Conduct Eligibility Audits

Findings:

Audits of typical civilian health care plans have found that a substantial portion of payments are made for patients who are not eligible for care. While the percentage of erroneous payments may be small, the savings can be large, given the amount of expenditures. The Task Force did not see any evidence of extensive eligibility audits conducted by DoD or analyses of the accuracy of the Defense Enrollment Eligibility Reporting System (DEERS) personnel system in determining eligibility.

Recommendations:

2.1 An independent audit of TRICARE is necessary to determine the adequacy of control measures that ensure that only those who are eligible are receiving care.

2.2 An audit of DEERS accuracy is needed beyond simply verifying ID cards at the point of service for care.

Altering Incentives in the Pharmacy Benefit

The Task Force was briefed on best practices in the public and private sectors to control prescription drug costs, including the provision of incentives to increase generic prescription use and the use of mail order pharmacy services and developed the following recommendations to lower future spending over what otherwise would have occurred.

3. Promote Mail Order and the Use of Generics

Findings:

Pharmacy services, including prescriptions filled at Military Treatment Facilities (MTFs) and outside of them, cost the DoD health care system $6.18 billion in 2006 and costs are expected to reach $15 billion by 2015, based on current trends. The Task Force heard convincing arguments that private sector plans have been able to reduce the growth in pharmacy costs while retaining clinical effectiveness by providing beneficiaries with greater incentives to utilize preferred drugs and fill maintenance prescriptions using mail order services. Generic drugs have the lowest copayment, followed by formulary drugs and nonformulary drugs. However, current DoD pharmacy copayment policies do not provide adequate incentives for patients to use the most cost-effective alternatives, such as the mail order pharmacy or an MTF. Employing financial incentives to encourage the use of the mail order pharmacy across all beneficiary groups should decrease retail pharmacy costs while preserving access to the local pharmacy.

Recommendations:

3.1 Copayments for prescriptions filled outside an MTF should be changed in order to alter incentives. DoD should increase the differentials in copayments to increase the use of more cost-effective practices. In its final report, the Task Force will make more specific recommendations about payment structure.

3.2 DoD should engage in an outreach program to publicize the value of using the TRICARE Mail Order Pharmacy (TMOP) program and generic drugs, utilizing the best practices followed by private companies in order to achieve savings.

Cost-Sharing and Realignment of Fee Structures

In recognition of the years of demanding service that military retirees have provided to the Nation, the Task Force believes that military retirees should receive health care benefits that are generous compared with U.S. public and private plans. Congress also has recognized this contribution. Much of the increase in the cost of DoD health care is attributed to explicit benefit expansion. Between 2000 and 2007, benefit expansion accounted for 64 percent of the increase in cost—57 percent for over-65 care and 7 percent for under-65 care.[1] However, when benefits have been expanded, it is not clear whether such expansions were implemented with an assessment of the impact that they would have on future costs or whether they were based on projections of the need for cost-sharing. The Task Force believes that cost-sharing policies must be set in such a way that they are fair to America's taxpayers by ensuring the judicious use of scarce federal resources.

4. Increase the Share of Costs Borne by Beneficiaries

Findings:

According to DoD, since 1996, military health care premiums paid by individual military retirees under age 65 utilizing DoD's most popular plan (TRICARE Prime) have fallen from 11 to 4 percent when measured as a percentage of total health care costs.[2] By comparison, premiums for employer-provided plans in the civilian sector decreased slightly, from 28 percent in 1996 to 25 percent in 2006.[3] Federal civilian retirees pay out-of-pocket costs of about 25 percent of total costs in the Federal Employees Health Benefit Plan (FEHBP).[4] A revised cost-sharing system would shift some costs, but more importantly, it could provide incentives for beneficiaries to change their behavior in ways that would slow the rate of cost growth. For example, revisions in cost-sharing may cause fewer retirees to drop private coverage in favor of TRICARE, and such revisions may foster more individual responsibility for wellness and preventive care.

---

1 John Kokulis, Special Assistant to the Assistant Secretary of Defense, Health Affairs, and Former Deputy Assistant Secretary of Defense, Health Affairs, Office of the Secretary of Defense. Sustaining the Military Health Benefit. Brief to the Task Force. January 16, 2007.
2 The Military Compensation System: Completing the Transition to an All-Volunteer Force. Report of the Defense Advisory Committee on Military Compensation. April 2006, p. 79.
3 Ibid.
4 FEHB law: Public Law 105-33, approved August 5, 1997.

Recommendations:

4.1 The portion of costs borne by beneficiaries should be increased to a level below that of the current FEHBP or that of generous private-sector plans and should be set at or below the level in effect in 1996. In its final report, the Task Force will recommend specific cost-sharing proposals and an accompanying set of enrollment fees and copayment levels.

4.2 Increases in cost-sharing should be phased in over three to five years to avoid precipitous changes. If Congress believes that increases in cost-sharing are too large relative to the amounts of retired pay, it should consider a one-time increase in military retired pay to offset part or all of the increase.

5. Index Premiums and Deductibles

Findings:

The Task Force notes that increases in medical inflation have, for some years, outpaced growth in overall inflation as measured by the Consumer Price Index. Even if Congress phases in an adjustment in cost-sharing for military retirees, as recommended above, the share gradually will fall unless actions are taken to index the costs borne by retirees.

Recommendations:

5.1 There should be an annual indexing of the premiums and deductibles paid by under-65 military retirees. In its final report, the Task Force will recommend a specific approach to indexing. In addition, periodic adjustment should be made to the catastrophic cap. These adjustments should avoid either frequent changes or increases that over time are excessively large.

5.2 Recommendation 5.1 will cause out-of-pocket costs for individual military retirees to rise more rapidly than their retired pay (which is increased annually based on the Consumer Price Index). All Americans face out-of-pocket health care costs that are rising faster than overall inflation. If Congress believes that retirees should not bear all of these added costs, it should periodically legislate special increases in retired pay to make up for some or all of the increases in the portion of retiree health care costs borne by individuals.

5.3 DoD should increase premiums and cost-sharing for under-65 military retirees so that the cost differential between TRICARE and private plans is smaller than it is currently. Premiums and deductibles should be indexed for increases on an annual basis according to an appropriate and widely acceptable index.

The Task Force has not yet had time to consider options for increasing or maintaining the use of private coverage. In its final report, it will explore a variety of potential strategies, for example:

- providing a stipend to employers to encourage a higher rate of use by employees who are eligible for TRICARE;
- providing a stipend to a health savings account to those who choose not to participate in TRICARE; and
- offering some form of supplemental coverage to under-65 retirees who retain their private health insurance and do not use TRICARE. This "TRIGAP" insurance would increase the incentive for retirees to maintain their private health care insurance. The coverage would be analogous to Medigap insurance and would be financed by DoD.

6. Tier the Payment Structure

Findings:

All military retirees, under age 65 or not otherwise Medicare-eligible, regardless of rank or retired compensation, pay the same individual or family enrollment fees. DoD has recommended that enrollment fees and deductibles vary in size based on an individual's pay grade at retirement, with higher-grade retirees paying larger amounts.

Recommendation:

6.1 Enrollment fees, deductibles, and copayments should be tailored to different circumstances, such as retired pay grade. However, further study is needed before proposing specific recommendations for variances in the beneficiary share of costs. In its final report, the Task Force will provide more specific recommendations.

Ensuring That TRICARE Is the Second Payer

7. Audit Compliance with TRICARE Law and Policy

Findings:

Although, under law, TRICARE is intended to be a second-payer system, insufficient data are available to conclude that it in fact is the second payer in all cases. In addition, the National Defense Authorization Act of Fiscal Year 2001 expanded TRICARE benefits for eligible beneficiaries who are 65 and older and enrolled in Medicare Part B. Under TRICARE for Life, TRICARE becomes the second payer to Medicare for medical care that is a benefit under both Medicare and TRICARE. The relatively small portion of TRICARE costs borne by individual retirees encourages retirees with access to private sector plans to drop their private coverage and rely on TRICARE as their primary plan. DoD estimates that approximately 72 percent of retirees under age 65 are working and have access to private sector health insurance.[5]

Recommendation:

7.1 DoD should commission an independent audit to determine the level of compliance with law and policy regarding TRICARE as second payer.

In sum, what is needed is a focus on preserving the best aspects of the current system, while improving and enhancing the delivery of accessible, quality health care over the long term. The system must be as effective and efficient as possible, while being affordable to the government and to beneficiaries, borrowing from best practices in the public and private sectors. Changes to the system should not be so excessive as to diminish the trust of beneficiaries nor lower the current high quality of health care services that are provided to Active Duty and Reserve military personnel, their dependents, and retirees.

---

5 The Military Compensation System: Completing the Transition to an All-Volunteer Force. Report of the Defense Advisory Committee on Military Compensation. April 2006, p. 78.

Introduction

The history of military health care dates back more than two centuries, when Congress enacted legislation requiring care for the "regimental sick" as well as care for the "relief of sick and disabled seamen." Subsequent legislation allowed for the care of military dependents, and later legislative language created provisions for care of military retirees and their dependents.

The provision of health services and health benefits is an established and significant mission of each service branch. In fact, the extent and volume of health care services provided through military programs have grown exponentially since World War II, resulting in the world's largest military health care system. This system serves several distinct classes of beneficiaries, including Active Duty military personnel, families of Active Duty personnel, reservists, and military retirees and their dependents. At the same time, unlike civilian health care systems, the Military Health System (MHS) must give priority to military readiness; the Nation's engagement in a long global war against terror; support of a conventional war if necessary; the provision of humanitarian relief and response to natural disasters; and the achievement of other missions required by national command authorities. The military health care system, which has evolved in various ways since its creation, was modified substantially in 1995, when the Department of Defense (DoD) initiated the TRICARE program. TRICARE was intended to better control the escalating costs of medical care, provide quality care for a downsized military, while caring for an ever increasing number of retired military beneficiaries, and to realign the system to the closure of many military medical facilities.

TRICARE provides medical care to eligible beneficiaries through a combination of direct care in military clinics and hospitals and civilian-purchased care. Medical services provided at Military Treatment Facilities (MTFs) include outpatient and inpatient care for medical and surgical conditions, pharmacy services, physical examinations, dental care, and diagnostic, laboratory, and radiological tests and services.

Impetus for This Report

Congressional concerns about the rising costs of the military health mission were reflected in Section 711 of the National Defense Authorization Act for Fiscal Year 2007, which established the Task Force on the Future of Military Health Care to make recommendations to Congress on a broad range of military health care issues. (See Appendix B for the complete charge to the Task Force.) The Task Force's final report to Congress is due December 2007; this interim report is to be delivered in May 2007. In announcing the creation of the Task Force, Deputy Defense Secretary Gordon England noted that "The military health program has many important challenges, the most critical being the rapidly growing costs of health benefit coverage and the need to make adjustments so this great program can continue far into the future."

Although the commitment to military health and readiness cannot waiver, current financial trends will pose significant challenges. Rising health care costs are due to a multitude of factors that are affecting not only DoD but also the country in general; theses factors include greater use of services, increasingly expensive technology and pharmaceuticals, and growing numbers of users.

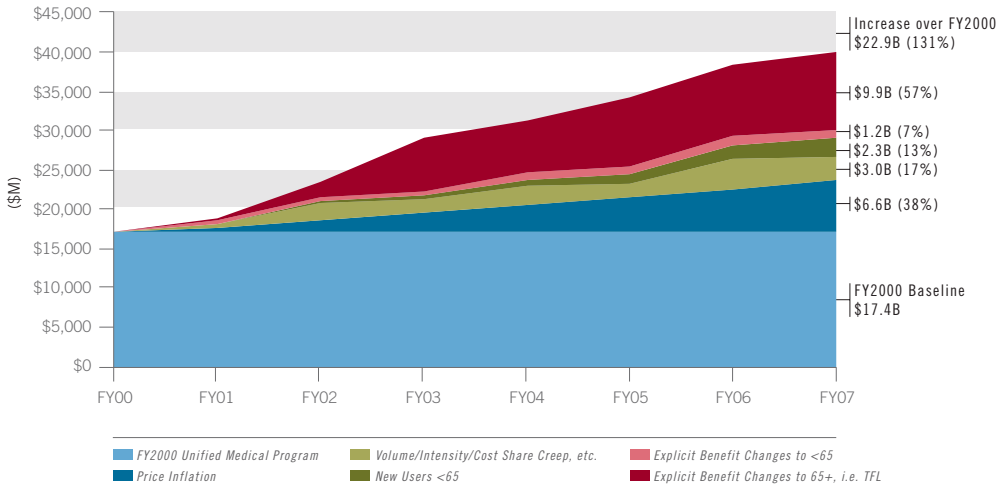
Costs of the military medical mission have doubled in the past five years from $19 billion in Fiscal Year 2001 to $38 billion in Fiscal Year 2006. The fastest rate of growth in DoD health care spending was in pharmacy services, which experienced a cumulative 238 percent increase between 2000 and 2005. TRICARE spending on prescription drugs more than tripled, from $1.6 billion in 2000 to $5.4 billion in 2005.[6]

At these rates of growth, analysts project costs of the MHS to reach $64 billion in 2015, with an expansion of the DoD military health budget from 8 to 12 percent of the entire DoD budget by 2015, up from 4.5 percent in 1990 (see Figure 1).[7] In addition, beneficiaries are paying exactly the same amount in terms of fees and copayments as they did 10 years ago. As a result, the portion of costs borne by beneficiaries has fallen from 27 percent of total costs in 1995 to 12 percent today.[8] Benefits also are increasing. While private sector organizations increasingly are scaling back on coverage and passing more costs to employees, DoD has expanded benefits and eliminated most cost shares for Active Duty personnel and their dependents, and also has added a TRICARE for Life benefit and the TRICARE Reserve Select program.

Although improvements in internal efficiency will be critical to containing costs, and the rebalancing of government and beneficiary cost shares is being explored, such measures will be insufficient to stem the tide of rising health care costs, although they may help to slow their rate of growth.

GROWTH IN THE UNIFIED MEDICAL BUDGET

(Excluding GWOT)



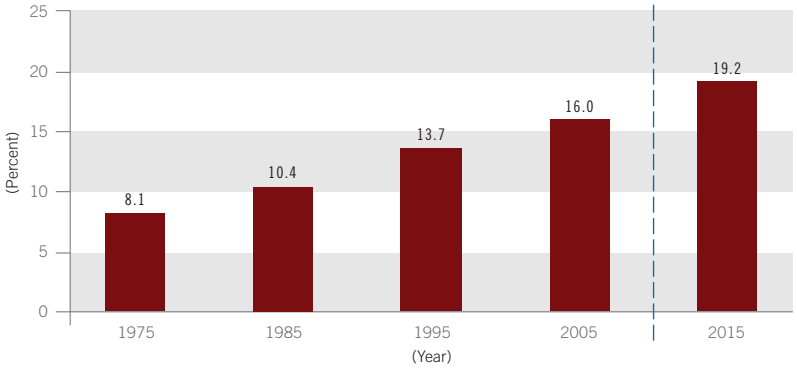
Source: John Kokulis, Special Assistant to the Assistant Secretary of Defense, Health Affairs, and Former Deputy Assistant Secretary of Defense, Health Affairs, Office of the Secretary of Defense. Sustaining the Military Health Benefit. Brief to the Task Force. January 16, 2007.

Figure 1

6 RADM Thomas McGinnis, TRICARE Management Activity, and CAPT Patricia Buss, DoD Pharmacy and Therapeutics Committee. Overview of the DoD Pharmacy Program. Brief to the Task Force. February 6, 2007.
7 John Kokulis, Special Assistant to the Assistant Secretary of Defense, Health Affairs, and Former Deputy Assistant Secretary of Defense, Health Affairs, Office of the Secretary of Defense. Sustaining the Military Health Benefit. Brief to the Task Force. January 16, 2007.
8 Ibid.

The DoD health care budget must be viewed within the context of the overall growth in health care spending in the United States, and any recommendations for change will be influenced by trends in the overall national health care economy. According to the Government Accountability Office (GAO), nationwide health care spending as a percentage of GDP totaled 16 percent in 2005, compared to 8.1 percent in 1975, and is projected to grow to 19.2 percent in 2015 (Figure 2).[9] Health care spending continues to increase at a rate greater than the rate of growth in the overall economy. Since 1970, health care spending has grown at an average annual rate of 9.9 percent, or about 2.5 percentage points faster than GDP.[10] Drivers of health care spending in general include population growth, increases in health insurance coverage, medical inflation, and increased utilization of services, both in terms of volume and intensity.

GROWTH IN HEALTH CARE SPENDING: HEALTH CARE SPENDING AS A PERCENTAGE OF GDP



Source: The Centers for Medicare & Medicaid Services, Office of the Actuary.
Note: The most current data available on health care spending as a percentage of GDP are for 2005. The figure for 2015 is projected.
GAO–07–766CG

Figure 2

Activities of the Task Force

The Task Force held its first meeting (administrative only) on December 21, 2006. During this meeting the group was oriented to its task and received background materials relating to its charge (see Appendix B). Task Force members appointed by the Secretary of Defense from outside of DoD elected a co-chair as directed by statute (the department co-chair was appointed by the Secretary of Defense). The members agreed to operate in a plenary fashion until the Task Force substantially completed this interim report, and they deferred a decision to establish subcommittees to study the broader range of issues that must be addressed in the final report.

9 David M. Walker. Comptroller General of the United States. DoD's 21st Century Health Care Spending Challenges. Brief to the Task Force. April 18, 2007.
10 Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2004; file nhegdp04.zip).

The Task Force convened seven public meetings in Washington, D.C., and one in San Antonio, Texas, to gather information pertinent to the topics listed in its charge. It received informational briefings and written statements and held discussions with stakeholders of the MHS and other experts in health care management and financing, with an emphasis on pharmacy matters. (See Appendix C for meeting dates, locations, speakers, and participating organizations.)

The Task Force also reviewed reports, studies, and reviews produced by GAO, the Assistant Secretary of Defense for Health Affairs, and others, to include—as specifically directed by Section 711(c)(2) —the findings and recommendations of the Healthcare for Military Retirees Task Group of the Defense Business Board (see Appendix D).

Several Task Force members made an informational visit to the United Mine Workers of America Health and Retirement Funds program to learn more about its health plan operations, in large part because of its highly regarded outreach program and pharmacy benefits management program. The Task Force also toured military medical facilities in San Antonio—the U.S. Army Institute of Surgical Research Burn Center at Fort Sam Houston and the Brooke Army Medical Center's Center for the Intrepid, a state-of-the-art rehabilitation facility. At these sites, the Task Force members received briefings related to regional care, hosted a town meeting, and held five panel hearings and discussions with groups consisting of spouses, retirees, members of the Guard and Reserve components, enlisted members, and officers.

The first public meeting of the Task Force was held on January 16, 2007. The Under Secretary of Defense (Personnel and Readiness) and Assistant Secretary of Defense, Health Affairs, provided information on the MHS, and key staff members of that office provided a detailed overview of the Defense Health Program, with an emphasis on budgetary and financial matters and the Administration's 2006 proposed legislation relating to these matters.

Four public meetings were held during February and March 2007. They included the following presentations and discussions:

- DoD representatives presented information on the pharmacy benefits program and TRICARE Managed Care Operations, including the specifics of cost-sharing between the government and beneficiaries;
- the Surgeons General of the Army and Navy, the Deputy Surgeon General of the Air Force, and the Joint Staff Surgeon spoke about direct care programs and deployed medicine;
- industry experts on the management and operation of health care programs and services (United Healthcare) gave presentations on the role of retail pharmacies in DoD's pharmacy program;
- representatives of beneficiary advocacy organizations provided their perspectives on the state of military health care, pharmacy, past legislation and legislative proposals, and cost-sharing;
- contractors responsible for TRICARE managed care support discussed operational issues; and
- contractors who have not bid on TRICARE contracts presented issues that discouraged their involvement in military health care.

Three meetings in April 2007, including the San Antonio visit, provided additional information on retail pharmacy and mail-order programs in addition to obtaining perspectives from industry experts on pharmacy issues.

About This Report

This Task Force was charged with a slate of objectives that includes assessment across the full range of military health operations and the development of recommendations on wellness initiatives, education programs, accurate cost accounting, universal enrollment, system command and control, the procurement process, military and civilian personnel mix, dual-eligible Medicare-eligible beneficiary needs, efficient and cost-effective contracts, and the beneficiary-government cost-sharing structure to sustain military health benefits over the long term. This cost-sharing structure is of significant importance, because the Task Force must report on this element in both its interim and final reports.

The authorizing language that established the Task Force stipulated that it submit an interim report on its activities to the Secretary of Defense and the Committees on Armed Services of the Senate and the House of Representatives. Specifically, the charge requires that the Task Force provide in this report its interim findings and recommendations regarding:

> (H) The beneficiary and Government cost-sharing structure required to sustain military health benefits over the long term… particularly with regard to cost-sharing under the pharmacy benefits program. (See Appendix B for the complete charge.)

Thus, this interim report focuses primarily on presenting preliminary findings and recommendations related to providing a pharmacy benefit that is cost-effective and that promotes accountability by all parties, including beneficiaries. In addition, it addresses other cost-sharing approaches and efficiencies with regard to the entire MHS. The Task Force will continue to consider issues related to these topics and will provide more specific guidance in its final report.

II Guiding Principles

Given the current and likely future commitments of the military, it is critical to address several persistent and new challenges facing today's current Military Health System. These include rising costs, the expansion of benefits, the increased use of benefits by military retirees and the Reserve military components, continued health care inflation, and TRICARE premiums that have been level for nearly a decade. These challenges must be considered in the contexts of the current and ongoing needs of Active Duty military personnel and their families, the aging of the military retiree population, and the broader backdrop of the U.S. health care economy, in which the military health care system operates. To sustain and improve military health care benefits for the long run, actions must be taken now to adjust the system in the most cost-effective ways.

The Task Force is an independent entity. Thus, based on the authorizing language creating it and its charge, its members have operated on the premise that deliberations would proceed with no preconceived outcomes or recommendations. Its starting points were established guidance in law, regulation, and policy. These guideposts framed discussions and served as departure points in the consideration of any potential changes to existing policy. The Task Force is conducting its deliberations in an open and transparent process, remaining accessible and responsive to all concerned constituencies.

In developing its recommendations, the Task Force seeks strategies that are based on the best possible information available, with rationales that can be clearly articulated. In addition, as recommendations are developed, their impact on beneficiaries, especially any financial impact, is explicitly addressed.

As its beginning step, the Task Force debated and adopted a set of guiding principles to use in assessing the desirability of recommended changes. The Task Force first adopted an overarching principle:

> **All recommended changes must focus on the health and well-being of beneficiaries and be cost-effective, taking into account both short- and long-term budgetary costs as well as the effects on the specific guiding principles noted below.**

The Task Force then adopted six specific guiding principles. These principles require that the changes recommended by the Task Force, when taken as a whole, must:

1) **maintain or improve the health readiness of U.S. military forces and preserve the capability of military medical personnel to provide operational health care globally;**
2) **maintain or improve the quality of care provided to beneficiaries, taking into account health outcomes as well as access to and productivity of care;**
3) **result in improvements in the efficiency of military health care by, among other approaches, reflecting best health care practices in the private sector and internationally;**

4) avoid any significant adverse effects on the ability of the military compensation system, including health benefits, to attract and retain the personnel needed to carry out the military mission effectively;

5) balance the need to maintain generous health care benefits in recognition of the demanding service rendered by military personnel to their country with the need to set and maintain a fair and reasonable cost-sharing arrangement between beneficiaries and DoD; and

6) align beneficiary cost-sharing measures to address fairness to taxpayers by promoting measures that enhance accountability and the judicious use of resources.

In sum, what is needed is a focus on preserving the best aspects of the current system, while improving and enhancing the delivery of accessible, quality health care over the long term. The system must be as effective and efficient as possible, while being affordable to the government and to beneficiaries, borrowing from best practices in the public and private sectors. Changes to the system should not diminish the trust of beneficiaries nor lower the current high quality of health care services that are provided to Active Duty and Reserve military personnel, their dependents, and retirees.

This interim report presents findings and recommendations that the Task Force believes are consistent with these guiding principles.

III Overview of the Military Health System

The mission of the Military Health System (MHS) is to provide health support for the full range of military operations and sustain the health of all who are entrusted to MHS care. This health support includes:

- providing patient care;
- sustaining the skills and training of medical personnel for peacetime and wartime;
- managing beneficiary care;
- promoting and protecting the health of the forces; and
- continuing to manage the benefits.

In Fiscal Year 2007, the MHS had total budget authority of $38 billion and served approximately 9.1 million beneficiaries, including Active Duty personnel and their families and retirees and their families (see Table 1).

Table 1: DoD TRICARE Eligible Beneficiary Population[11]

POPULATION	FY 2007
Active Duty	1,656,593
Active Duty Family Members	2,288,268
TRICARE Eligible Retirees (under 65)	1,102,493
TRICARE Eligible Retiree Family Members (under 65)	2,181,327
Subtotal TRICARE Non-Active Duty Under 65 Eligible	5,572,088
Medicare Eligible (65 and older)	1,903,387
Total	9,132,068

The MHS includes 133,000 personnel—86,000 military and 47,000 civilian—working at more than 1,000 locations worldwide, including 70 inpatient facilities and 1,085 medical, dental, and veterinary clinics.[12]

Sources of MHS Funding

The MHS relies on a complicated appropriations process with several fluctuating components that make tracking over time complex. The MHS receives its funding from numerous appropriations sources with different timeframes and restrictions. The most significant source is the Defense Health Program (DHP) Operations and Maintenance (O&M) appropriation, which must be obligated in one fiscal year, but two percent of the total can be carried over to the next fiscal year.

---

11 Allen Middleton, Acting Deputy Assistant Secretary of Defense for Health Affairs and Acting Chief Financial Officer, TRICARE Management Activity. The Military Health System (MHS) and the Defense Health Program (DHP): An Overview for the Task Force on the Future of Military Healthcare. Brief to the Task Force. January 16, 2007.
12 Ibid.

The DHP O&M appropriation funds day-to-day operations across a wide variety of medical, dental, and veterinary services. This appropriation also funds readiness that is not already funded by the Service line appropriations, education and training, occupational health and industrial health care, and facilities and information technology. Other appropriations under the DHP include the following: Research, Development, Test, and Evaluation (RDT&E), which is a two-year appropriation, and Other Procurement (OP), which is a three-year appropriation. The DHP O&M appropriation does not compensate military personnel working at Military Treatment Facilities (MTFs). The Military Personnel (MilPers) appropriation is not under DHP, but it covers compensation of all military personnel. The Military Construction appropriation is another appropriation that supports the MHS but is not under the DHP.

The TRICARE Program

TRICARE replaced CHAMPUS in 1994, becoming a triple-option rather than a dual-option system. TRICARE utilizes the health care resources of the Army, Navy, and Air Force and supplements these services with networks of civilian health care providers. The first TRICARE Region began operations in March 1995. By June 1998, implementation of the regionally managed health care program was complete for Active Duty, activated Guard and Reserves, and retired members of the Uniformed Services, their families, and survivors.

Military dependents and retirees must choose among three TRICARE options:

- TRICARE Prime, a voluntary health maintenance organization (HMO)-type option, in which MTFs are the principal source of health care;
- TRICARE Extra, a preferred provider option (PPO); or
- TRICARE Standard, a fee-for-service option (the original CHAMPUS program).

Guard and Reserve service members on Active Duty are automatically enrolled in TRICARE Prime. The philosophical and actual movement of the Guard and the Reserve from a strategic force to an operational force is causing increased demands on and costs to the MHS, the total impact of which are not yet clear.

In October 2004 the Transition Assistance Management Program (TAMP) was implemented to provide TRICARE for 180 days following active duty. In April 2005, the TRICARE Reserve Select program was launched to provide a premium-based TRICARE Health Plan offered for purchase to Reserve Component members who qualify. In 2006, TRICARE benefits were extended to dependents whose sponsor died on Active Duty.

Tables 2 and 3 compare fees and cost-sharing for the eligible populations.

Table 2: TRICARE Fees—Eligible Active Duty, Guard, and Reserve Family Members

	TRICARE PRIME	TRICARE EXTRA	TRICARE STANDARD
Annual Deductible	None	$150/individual or $300/family for E-5 and above; $50/$100 for E-4 and below	$150/individual or $300/family for E-5 and above; $50/100 for E-4 and below
Annual Enrollment Fee	None	None	None
Civilian Outpatient Visit	No cost	15% of negotiated fee	20% of allowed charges for covered service
Civilian Inpatient Admission	No cost	Greater of $25 or $14.35/day	Greater of $25 or $14.35/day
Civilian Inpatient Behavioral Health	No cost	Greater of $20 per day or $25 per admission	Greater of $20 per day or $25 per admission
Civilian Inpatient Skilled Nursing Facility Care	$0 per diem charge per admission	$11/day ($25 minimum) charge per admission	$11/day ($25 minimum) charge per admission
	No separate copayment/cost share for separately billed professional charges		

Table 3: TRICARE Fees: Retirees (Under 65), Their Family Members, and Others

	TRICARE PRIME	TRICARE EXTRA	TRICARE STANDARD
Annual Deductible	None	$150/individual or $300/family	$150/individual or $300/family
Annual Enrollment Fee	$230/individual $460/family	None	None
Civilian Cost Shares		20% of negotiated fee	25% of allowed charges for covered service
Outpatient Emergency Care Mental Health Visit	$12 $30 $25 $17 (group visit)		
Civilian Inpatient Cost Share	Greater of $11 per day or $25 per admission; no separate copayment for separately billed professional charges	Lesser of $250/day or 25% of negotiated charges, plus 20% of negotiated professional fees	Lesser of $535/day or 25% of billed charges, plus 25% of allowed professional fees
Civilian Inpatient Skilled Nursing Facility Care	$11/day ($25 minimum) charge per admission	$250 per diem cost share or 20% cost share of total charges, whichever is less, institutional services, plus 20% cost share of separately billed professional charges	25% cost share of allowed charges for institutional services, plus 25% cost share of allowable for separately billed professional charges
Civilian Inpatient Behavioral Health	$40 per day; no charge for separately billed professional charges	20% of total charge, plus, 20% of the allowable charge for separately billed professional services	High-volume hospitals—25% hospital specific per diem, plus 25% of the allowable charge for separately billed professional services; low-volume hospitals—$175 per day or 25% of the billed charges, whichever is lower plus 25% of the allowable charge for separately billed services

TRICARE for Life

Effective October 2001, TRICARE for Life (TFL) began providing lifelong comprehensive health care coverage to the 784,000 military retirees, 391,000 spouses, and 214,000 survivors eligible for Medicare because of age (65 and older) or disability.[13]

TFL is available for all dual TRICARE-Medicare-eligible Uniformed Services retirees, including:

- retired members of the Reserve Component who are in receipt of retired pay;
- Medicare-eligible family members;
- Medicare-eligible widows/widowers;
- certain former spouses; and
- beneficiaries under age 65 who are also entitled to Medicare Part A because of a disability or chronic renal disease.

Dependent parents and parents-in-law are not eligible for TRICARE benefits, except for TRICARE Senior Pharmacy benefits on a space-available basis at an MTF. In order to be eligible for TRICARE Senior Pharmacy benefits, they must be entitled to Medicare Part A, and if they have turned age 65 on or after April 1, 2001, they must be enrolled in Medicare Part B. Enrollment in Medicare Part D is not necessary. The TRICARE pharmacy benefit is considered creditable coverage and pays equally to Medicare.[14]

There are no enrollment fees for TFL; however, beneficiaries are required to purchase Medicare Part B. For services payable by both Medicare and TFL, Medicare pays first, any other health insurance pays second, and the remaining beneficiary liability may be paid by TFL. If services are rendered by a civilian provider, the provider first files claims with Medicare. Medicare pays its portion and then forwards the claim to TFL for processing. Then, TFL sends its payment for the remaining beneficiary liability directly to the provider.

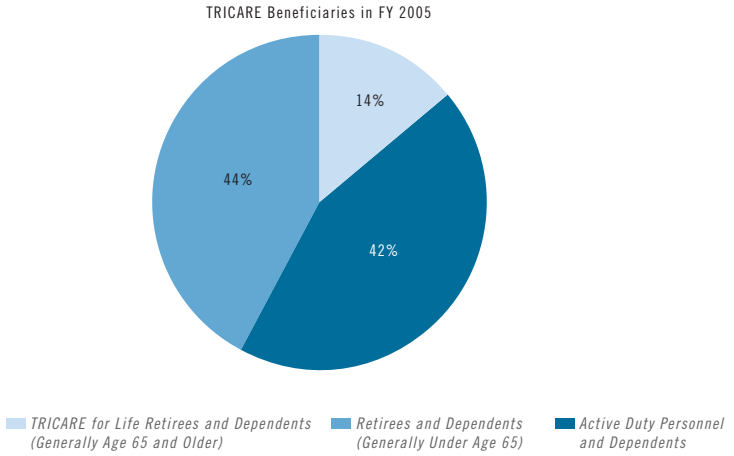
Nearly two million beneficiaries are over the age of 65 and otherwise eligible for Medicare, according to an April 2006 report of the Defense Advisory Committee on Military Compensation. The report cites Congressional Budget Office estimates that project that by 2013 the TFL benefit will increase DoD healthcare costs by 44 percent.[15]

---

13 See www.afa.org/magazine/dec2000/1200tricare.asp.
14 See www.tricare.mil/medicarepartd/pdcc.cfm.
15 The Military Compensation System: Completing the Transition to an All-Volunteer Force: Report of the Defense Advisory Committee on Military Compensation. April 2006.

Figure 3 depicts the status of TRICARE beneficiaries in Fiscal Year 2005. A majority of beneficiaries are not Active Duty personnel: 44 percent are retirees and dependents (generally under age 65), and 14 percent are TFL retirees and dependents (generally age 65 and older).

MAJORITY OF TRICARE BENEFICIARIES ARE NOT ACTIVE DUTY PERSONNEL



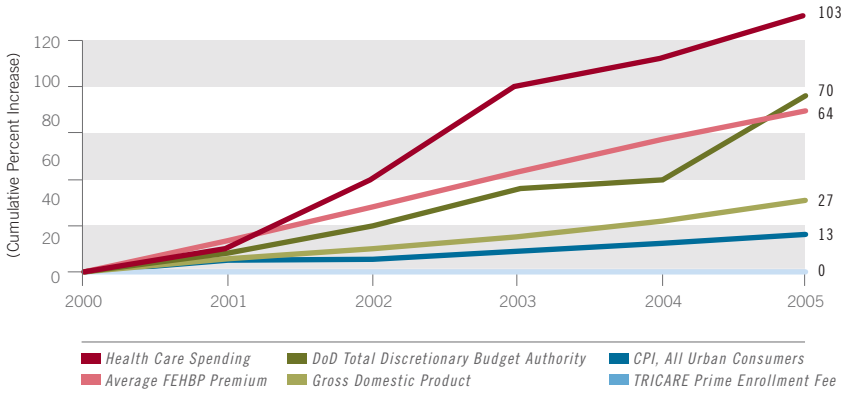
Source: GAO–07–48

Figure 3

Comparison of Growth of DoD Health Care Spending with Other Indicators

As of 2005, DoD health care spending has increased by more than 100 percent since 2000, while the cumulative increase in the DoD total discretionary budget authority grew 70 percent (see Figure 4) over this period. During the same five-year period, the average Federal Employees Health Benefits Program (FEHBP) premium (available to federal civilian employees) grew 64 percent, while the TRICARE Prime Enrollment Fee remained unchanged (see Figure 4).

COMPARISON OF GROWTH IN DoD HEALTH CARE SPENDING, TRICARE ENROLLMENT FEES, OTHER INSURANCE PREMIUMS, AND ECONOMIC INDICATORS



Source: DoD, Bureau of Economic Analysis, Bureau of Labor Statistics, and Office of Personnel Management.
Note: The most current data available on DoD health care spending are for 2005.
GAO–07–766CG

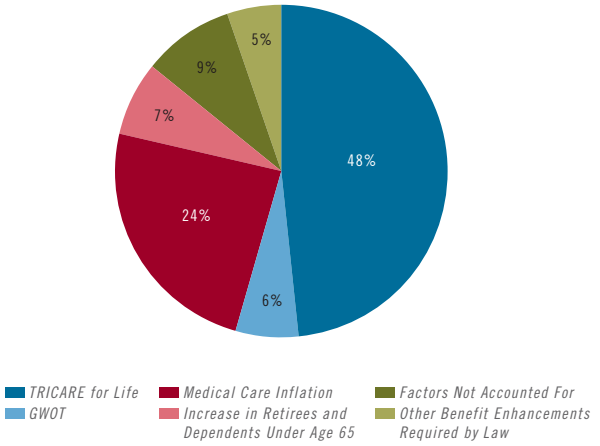
Figure 4

The fastest rate of growth in DoD health care spending was in pharmacy, which experienced a cumulative 202 percent increase between 2001 and 2006. TRICARE spending on prescription drugs more than tripled, from $2 billion in 2001 to $6.2 billion in 2006, for approximately 16 percent of the Unified Medical Budget.[16,17,18]

16 NetCharts NDX Data, A-RX 30 Day adjusted prescriptions. April 24, 2007. https://rxportal.army.mil.
17 The Fiscal Year 2006 Unified Medical Budget was $38B, according to John Kokulis, Special Assistant to the Assistant Secretary of Defense, Health Affairs. and Former Deputy Assistant Secretary of Defense, Health Affairs, Office of the Secretary of Defense. Sustaining the Military Health Benefit. Brief to the Task Force. January 16, 2007.
18 NetCharts NDX Data, A-RX 30 Day adjusted prescriptions. April 24, 2007. https://rxportal.army.mil.

Figure 5 depicts estimates of factors contributing to increases in DoD's health care spending, of which nearly half can be attributed to the TFL benefit.

DoD ESTIMATES OF FACTORS CONTRIBUTING TO INCREASES IN DoD'S HEALTH CARE SPENDING, FY2000–FY2005



Source: DoD
GAO–07–766CG

Figure 5

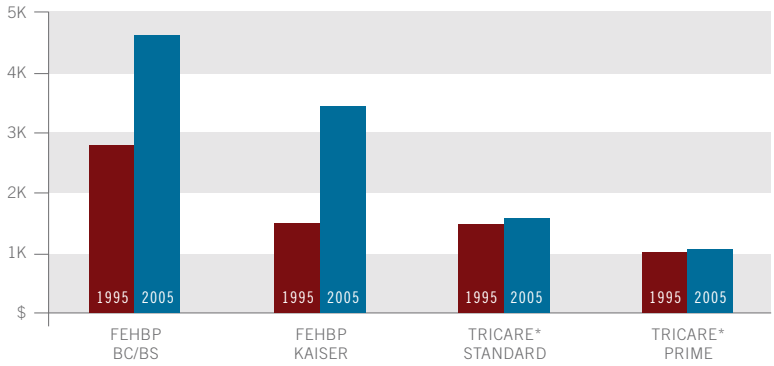
Over the last decade, the government's share of TRICARE's financing has grown, while beneficiaries' costs have remained unchanged or have been lowered, due to the following:

- no enrollment fee for TRICARE Standard and Extra and no increase in the enrollment fee for TRICARE Prime since 1996;
- the lowering of the catastrophic capitation for the under-65 retirees and dependents in 2001 (from $7,500 to $3,000);
- no increase in TRICARE deductibles since 1996;
- the elimination of TRICARE Prime copayments for dependents of Active Duty service members;
- congressional expansion of benefits four times since 2001; and
- the declining out-of-pocket share for TRICARE costs that has resulted from medical inflation. (DoD reports that under-65 retirees and dependents paid 12 percent of their health care costs in Fiscal Year 2005, down from 27 percent in Fiscal Year 1996[19]) (see Figures 6 and 7).

19 David M. Walker. Comptroller General of the United States. DoD's 21st Century Health Care Spending Challenges. Brief to the Task Force. April 18, 2007.

TRICARE COST SHARES HAVE REMAINED FLAT

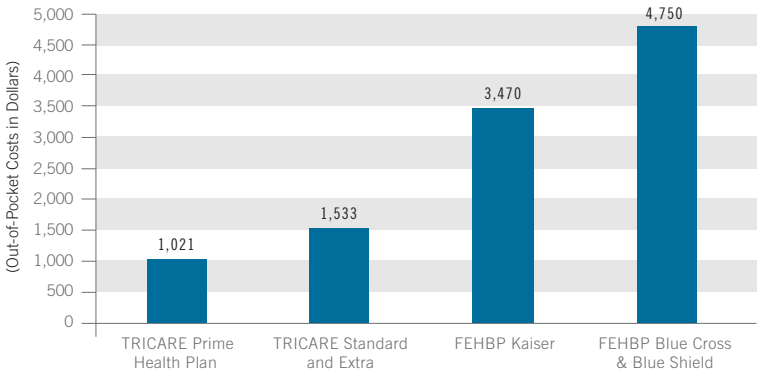
Low Out-of-Pocket Expenses Comparison*



**Depicts costs for a TRICARE Retiree Family of 3 for care received in the private sector.*
Source: DoD

Figure 6

COMPARISON OF AVERAGE OUT-OF-POCKET COSTS–INCLUDING PREMIUMS, COPAYMENTS, COINSURANCE, AND DEDUCTIBLES–FOR A FAMILY OF THREE IN VARIOUS HEALTH PLANS, 2005



Source: DoD
GAO–07–766CG

Figure 7

It is worth noting that there also are health plan differences between TRICARE and other federal and private sector plans.[20] For example, TRICARE counts a beneficiary's enrollment fee toward the catastrophic cap on the beneficiary's out-of-pocket costs, while other public and private payers exclude a beneficiary's premium from counting toward the cap.

20 Ibid.

TRICARE copayment requirements for prescription drugs are not structured to encourage the use of the less expensive mail order option over the use of more expensive retail pharmacies. Best practice suggests the general rule of thumb is that mail is twice retail with commercial economics (this assumes a 30-day fill for retail and 90-day fill for mail).[21] The average Express Scripts plan has a $10 copayment for retail generic and $20 for mail order generic.[22] In Fiscal Year 2004, TRICARE beneficiaries obtained more than twice as many prescriptions from retail pharmacies as from mail order pharmacies. Other payers use stronger financial incentives to steer patients toward the least costly option. In addition, because out-of-pocket costs for prescription drugs are so low, TFL beneficiaries have little incentive to enroll in Medicare Part D, which can have more aggressive cost-sharing requirements.

Internal Control Issues

Controllership presents unique challenges within the overall rubric of the military health care system's financial sustainability. Controllership has been defined as a commitment to compliance, effectiveness, and integrity that spells out how each is to be achieved.[23] Federal management is responsible for establishing and maintaining internal controls to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations.[24] On December 21, 2004, the Office of Management and Budget (OMB), pursuant to its authority under the Federal Managers' Financial Integrity Act of 1982,[25] issued revisions to OMB Circular A-123, Management's Responsibility for Internal Control.[26] OMB Circular A-123 provides guidance to federal managers on improving the accountability and effectiveness of federal programs and operations by establishing, assessing, correcting, and reporting on internal control.[27] DoD's Managers' Internal Control Program was established to review, assess, and report on the effectiveness of internal controls within DoD.[28] Part of the program's intent is to identify and promptly correct ineffective internal controls and establish more effective internal controls when warranted.[29]

However, DoD has struggled at times to properly exercise internal controls over its assigned programs. In a February 2004 report, the General Accounting Office (GAO) noted that DoD was not collecting tens of millions of dollars annually because key information required to effectively bill and collect funds from third-party insurers often was not collected, recorded, or even used by MTFs.[30] DoD auditors even observed that while DoD collected $122 million annually from Fiscal Years 2000 through 2002, a further $44 million could have been collected at 35 of the largest 122 MTFs.[31] GAO confirmed that these findings, along with others previously uncovered,[32] suggest that billing and collection problems are pervasive throughout DoD.[33] The single largest obstacle to increasing collections, according to GAO, was the inadequate identification of patients with third-party insurance, and this resulted from the lack of an adequate system or process that could obtain the needed information.[34]

---

21 Nancy Gilbride and Steven B. Miller. Express Scripts. Brief to the Task Force. April 18, 2007.
22 Ibid.
23 Robert A. Parker. The Company He Keeps. Controller Magazine. March 1998, p.19. www.businessfinancemag.com/magazine/archives/article.html?articleID=4322.
24 OMB Director's Letter to Heads of Executive Departments and Establishments, dated December 21, 2004, para. 1. www.whitehouse.gov/omb/circulars/a123/a123_rev.pdf.
25 31 U.S.C § 3512 (2004).
26 OMB Controller's Memorandum to Chief Financial Officers, Chief Operations Officers, Chief Information Officers, and Program Managers, dated December 21, 2004. www.whitehouse.gov/omb/circulars/a123/a123_rev.pdf.
27 Ibid.
28 DoD Instruction 5010.40 §4. Managers' Internal Control (MIC) Program Procedures. January 4, 2006.
29 Ibid.
30 U.S. General Accounting Office. Military Treatment Facilities: Improvements Needed to Increase DoD Third Party Collections. GAO-04-322R, p.2. Washington, D.C. February 20, 2004.
31 Ibid.
32 See, e.g., U.S. General Accounting Office. Military Treatment Facilities: Internal Control Activities Need Improvement. GAO-03-168. Washington, D.C. October 25, 2002.
33 U.S. General Accounting Office. Military Treatment Facilities: Improvements Needed to Increase DoD Third Party Collections. GAO-04-322R, p. 2. Washington, D.C. February 20, 2004.
34 Ibid., at p.3.

Eligibility Determinations

In response to its legal obligation, DoD has implemented internal controls regarding the eligibility and payment of funds for medical and dental care. For example, the eligibility of members and certain former members of the Uniformed Services to receive medical and dental care is outlined in federal law.[35] Medical and dental care eligibility for dependents also is contained in federal law.[36] The Code of Federal Regulations speaks exhaustively to medical and dental care eligibility within the TRICARE program for individuals whose relationship to the military sponsor leads to entitlement to benefits.[37] The Services have promulgated regulations regarding eligibility to receive medical and dental services.[38] Regarding payment of funds for services rendered, Congress has authorized the military services to bill insurance companies under the Third Party Collections Program to help pay the rising cost of providing health care to a growing number of eligible beneficiaries.[39] DoD promulgated an instruction detailing the specifics of the Third Party Collection Program.[40]

DoD is responsible for the distribution of authorized medical and dental benefits and entitlements as prescribed in Chapter 55 of Title 10, United States Code.[41] The Defense Enrollment Eligibility Reporting System (DEERS) is the designated automated information system designed to provide timely and accurate information on those eligible for medical and dental benefits and entitlements and to prevent and detect fraud and abuse in the distribution of these benefits and entitlements.[42] It is the definitive data source to identify and verify affiliation with the DoD.[43] DEERS serves as the centralized personnel data repository that supports and maintains this policy in a uniform fashion.[44] DEERS is updated by batch transactions from the Uniformed Services automated personnel, finance, medical, and mobilization management systems, the Department of Veterans Affairs, and the Centers for Medicare and Medicaid Services.[45] DEERS is also accessed and updated by online DEERS client applications.[46] Registration in DEERS is required for TRICARE eligibility.[47]

When a patient presents for care, eligibility for that care should be established. The Services use a two-step process to determine eligibility to receive medical or dental care.[48] Designated MTF personnel ensure that all patients, including those in uniform, show valid identification to confirm the patient's identity before they provide routine care, ancillary, or administrative services and look up the patient's status within DEERS to verify entitlement.[49] If the beneficiary's eligibility cannot be verified, a locally developed form is filled out and the patient is counseled that he or she must return with verification of eligibility within 30 days or he or she will be billed for care rendered.[50]

---

35 10 U.S.C. § 1074 et seq. (2004).
36 10 U.S.C. § 1076 et seq. (2004).
37 32 C.F.R § 199.3 et seq. (2007).
38 See, e.g., AFI 41-210. Patient Administration Functions, §3.1 (Establishing Eligibility for Care. March 22, 2006; AFI 41-115 et seq., Authorized Health Care and Health Care Benefits in the Military Health System. December 28, 2001.
39 10 U.S.C. § 1095 (2004).
40 DoD 6010.15-M. Military Treatment Facility Uniform Business Office Manual, Chapter 4. November 9, 2006.
41 DoD Instruction 1341.2, Defense Enrollment Eligibility Reporting System (DEERS) Procedures, § 4 (March 19,1999).
42 Ibid.
43 TRICARE Systems Manual 7950.1-M, DEERS, §2.1 (Change 43, May 7, 2007 to the August 1, 2002 edition.)
44 DoD Instruction 1341.2, Defense Enrollment Eligibility Reporting System (DEERS) Procedures, § 4 (March 19,1999).
45 Ibid.
46 Ibid.
47 DEERS Information Home on TRICARE website. www.tricare.mil/deers/default.cfm.
48 See AFI 41-210, Patient Administration Functions, §3.1 (Establishing Eligibility for Care) (22 March 2006).
49 Ibid, at §3.1.2.1.
50 Ibid, at §3.1.2.4.

IV Overview of the DoD Pharmacy Program

Title 10 of the U.S. Code provides the legal foundation for DoD to provide a uniform program of medical and dental care for members and certain former members of the military services, and for their dependents.[51] The same provision also requires the Secretary of Defense to establish an effective, efficient, and integrated pharmacy benefits program. Under this pharmacy benefits program, the Secretary must ensure the availability of pharmaceutical agents for all therapeutic classes, establish a uniform formulary based on clinical effectiveness and cost-effectiveness, and assure the availability of clinically appropriate pharmaceutical agents to members of the Uniformed Services. The Secretary of Defense implemented this key component of the TRICARE program, the current TRICARE Pharmacy Program, effective May 3, 2004.[52]

TRICARE provides a pharmacy benefit to all eligible Uniformed Services members, including TRICARE for Life (TFL) beneficiaries. TFL beneficiaries who turned age 65 on April 1, 2001, or later must be enrolled in Medicare Part B to use the TRICARE retail and mail order pharmacy programs. Beneficiaries who turned 65 prior to April 1, 2001, do not have to be enrolled in Medicare Part B to use the TRICARE Pharmacy Program; however, they must be enrolled to use other TRICARE benefits.

Factors Influencing Expenditures

There are several factors contributing to the increase in pharmacy expenditures within the Military Health System (MHS):

- limited discounts at the retail point of service coupled with increasing usage;
- since the implementation of TFL, retail prescription usage and costs have been the main cost driver contributing to the significant increases in MHS pharmacy costs; pharmaceutical costs for those under 65 years of age average $437 per eligible beneficiary compared to $1,784 for those who are 65 years of age or older, a difference of $1,347 per eligible beneficiary;[53]
- increased numbers of eligible beneficiaries, from 8.6 million (Fiscal Year 2002) to 9.2 million (Fiscal Year 2006), and increased numbers of users of the benefit, from 5.7 million (Fiscal Year 2002) to 6.7 million (Fiscal Year 2006);
- no change in pharmacy copayments since the inception of the TRICARE Senior Pharmacy (TSRx) program in 2001;
- maximum nonformulary copayments are stipulated in law; and
- limited leverage to optimize drug utilization management in the network point of service compared to the Military Treatment Facility (MTF).

51 10 U.S.C. §§ 1071, 1073 (2004).
52 See 69 Fed. Reg. 17035 (April 1, 2004) (noting that the final rule becomes effective May 3, 2004).
53 Major Wade Tiller and Dave Bretzke. DoD Pharmacoeconomic Center. PEC Brief. April 11, 2007.

Points of Service

To have a prescription filled, beneficiaries need a written prescription and a valid Uniformed Services identification card. Eligible beneficiaries may fill prescription medications at four outpatient pharmacy points of service:

1. MTFs;
2. Retail Network Pharmacies: non-MTF pharmacies that are part of the network established for the TRICARE Retail Pharmacy (TRRx) program;
3. retail non-network pharmacies: non-MTF pharmacies that are not part of the network established for TRICARE retail pharmacy services; and
4. TRICARE Mail Order Pharmacy (TMOP).

Copayment Structure

Title 10 of the U.S. Code establishes cost-sharing requirements for the pharmacy benefits program.[54] Cost shares, when collected by the government for prescriptions dispensed through the retail network pharmacies or TMOP, help defray government costs of administering the pharmacy benefits program and can be used to encourage (or discourage) certain types of behavior. The current TRICARE Pharmacy Program covers at least a portion of a beneficiary's cost of prescription drugs when the beneficiary acquires the drugs from one of the four sources cited above. The amount of cost-sharing between beneficiaries and DoD varies depending on the source of the prescription drugs obtained.

Beneficiaries currently pay the pharmacy copayment based on whether the prescription medication is classified as a formulary generic drug (Tier 1), a formulary brand name drug (Tier 2), or a nonformulary drug (Tier 3) drug. The copayment depends on where the beneficiary chooses to fill his or her prescription.

Beneficiaries may fill their prescriptions at an MTF, through the TMOP, or at one of the more than 58,650 TRRx locations in the nationwide network.[55] Beneficiaries also can fill prescriptions at non-network pharmacies, but will pay significantly more and must meet a deductible.

Active Duty service members are not required to make copayments on their prescriptions. However, if they receive medications through an overseas pharmacy or an out-of-network pharmacy, they may need to pay out-of-pocket expenses for the total cost of the medication and then file a claim for reimbursement for the full amount.

The copayment structure applies to all TRICARE beneficiaries. Beneficiaries have no copayment when they obtain drugs from an MTF.[56] However, beneficiaries must pay a copayment when they obtain drugs from other points of service. A comparison of the point-of-service copayment and the associated quantity of medication dispensed is presented in Table 4.[57]

---

54 10 U.S.C. § 1074g(a)(6) (2004).
55 RADM Thomas McGinnis and CAPT Patricia Buss. DoD Pharmacy and Therapeutics Committee. Overview of the Department of Defense Pharmacy Program. February 6, 2007.
56 32 C.F.R. § 199.21(i)(2)(i) (2006).
57 See www.tricare.mil/pharmacy/copay.cfm.

Table 4: TRICARE Pharmacy Copayments in the United States and Territories

	UNIFORM FORMULARY		
	FORMULARY		
PLACE OF SERVICE	GENERIC (TIER 1)	BRAND NAME (TIER 2)	NONFORMULARY (TIER 3)
MTF pharmacy (up to a 90-day supply)	$0	$0	Not Applicable
TMOP (up to a 90-day supply)	$3	$9	$22
TRRx (up to a 30-day supply)	$3	$9	$22
Non-network retail pharmacy (up to a 30-day supply) **Note:** Beneficiaries using non-network pharmacies may have to pay the total amount of their prescription first and then file a claim to receive partial reimbursement.	**For those who are not enrolled in TRICARE Prime:** $9 or 20% of total cost, whichever is greater, after deductible is met (E1-E4: $50/person; $100/family; all others, including retirees, $150/person, $300/family) **TRICARE Prime:** 50 percent cost share after point-of-service deductibles ($300 per person/ $600 per family deductible)		**For those who are not enrolled in TRICARE Prime:** $22 or 20% of total cost, whichever is greater, after deductible is met (E1-E4: $50/person; $100/family; all others, including retirees, $150/person, $300/family) **TRICARE Prime:** 50 percent cost share after point-of-service deductibles ($300 per person/ $600 per family deductible)

	BENEFICIARY COPAYMENT AT OVERSEAS LOCATIONS			
	ACTIVE DUTY SERVICE MEMBERS	ACTIVE DUTY FAMILY MEMBERS (ADFMS) ENROLLED IN PRIME	ADFMS NOT ENROLLED IN PRIME	RETIREES AND FAMILY MEMBERS
Copayment	No copayment	No copayment	20% cost share after deductible of $50/100 for E1-E4 ADFMs; $150/300 for E5 and above ADFMs is met	25% cost share after deductible of $150/300 is met

The copayment structure has not changed since 2001. The MHS does not have an index to inflation as does the Centers for Medicare and Medicaid Services (CMS) with the Part D drug benefit (although this is less problematic than not having an index to the premium or deductible). There is a maximum nonformulary copayment, which is a percentage of the total costs in the third tier. This figure is 20 percent for Active Duty beneficiaries and 25 percent for retirees. Currently, this amount ($22) is not a large enough difference between the second and third tiers to drive utilization back into a formulary drug or into generic drugs.

The established copayments may be adjusted periodically based on experience with the uniform formulary, changes in economic circumstances, and other appropriate factors.[58] Adjustments may be made upon the recommendation of the DoD Pharmacy and Therapeutics Committee and approved by the Assistant Secretary of Defense, Health Affairs.[59] However, adjustment amounts must be compliant with the requirements of 10 U.S. 1074g(a)(6).[60] Under those provisions, the Secretary of Defense may establish cost-sharing requirements in a percentage or fixed dollar amount under the pharmacy benefits program for

58 32 C.F.R. § 199.21(i)(2)(ix) (2006).
59 Ibid.
60 Ibid.

generic, formulary, and nonformulary agents.[61] For the highest copayment category, the nonformulary or third-tier category, the law limits this amount to 20 or 25 percent.

TRICARE's mandatory generic drug policy requires that prescriptions be filled with a generic product if one is available. Brand name drugs that have a generic equivalent may be dispensed only if the prescribing physician is able to justify medical necessity for use of the brand name drug. If a generic-equivalent drug does not exist, the brand name drug will be dispensed at the brand name copayment rate.

The MHS average cost of a retail prescription for 30-day equivalents is $70 as of March 2007.[62] In the retail network, 62 percent of those prescriptions are for generic medications, in line with CMS benchmark numbers of 60 percent. For TMOP, the average cost is $34.[63] The MTF remains the lowest cost point at $19; it is the most cost-effective option for both the government and beneficiaries when drugs are available and accessible.[64] The retail point of sale has a generic fill rate in excess of 53 percent.[65] However, it is not clear whether these data reflect the actual costs of dispensing. To truly understand the differences in costs, DoD would have to ensure that the total costs of dispensing—not just drug costs—are included in cost comparisons. Moreover, cost comparisons must be made using specific medications.

Beneficiaries and Usage of the Pharmacy Benefit

Of the 9.2 million eligible beneficiaries in the MHS, 73 percent, or 6.7 million, used the pharmacy benefit in Fiscal Year 2006 (see Table 5).

Table 5: Unique User Trends

POINT OF SERVICE	FY02	FY03	FY04	FY05	FY06
MTF only	3,454,419	3,574,200	3,319,477	3,031,537	2,833,312
Retail only	1,033,576	1,264,787	1,500,504	1,820,899	1,992,616
Mail Order only	79,124	83,654	64,605	61,343	55,076
MTF & Retail only	814,048	927,717	1,104,689	1,253,612	1,297,796
MTF & Mail Order only	54,885	37,777	42,791	45,569	45,752
Retail & Mail Order only	181,881	206,748	256,927	288,287	331,587
MTF, Mail Order & Retail	96,130	101,119	101,110	112,572	121,180
Total Unique Users	5,714,063	6,187,185	6,390,103	6,612,378	6,685,709
Eligible Beneficiaries	8,671,727	8,929,071	9,154,440	9,210,547	9,177,548
%of Eligible Beneficiaries Using Pharmacy Benefit	66%	69%	70%	72%	73%

Source: DoD Pharmacy Data Transaction Service

Pharmacy expenditures in Fiscal Year 2006 totaled $6.18 billion and are expected to reach $15 billion by Fiscal Year 2015.[66]

---

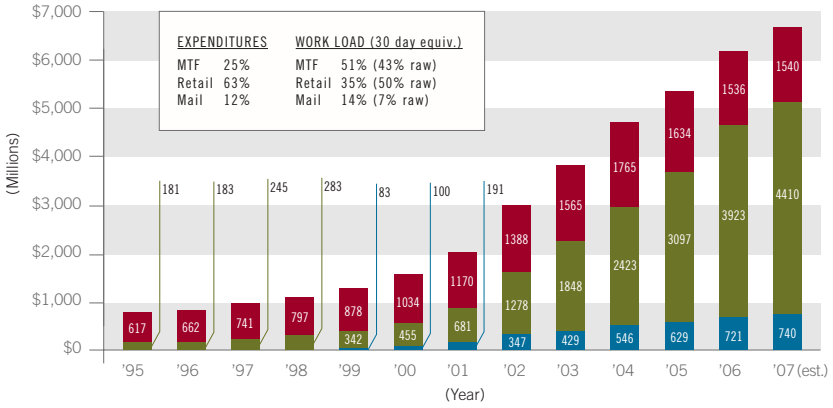
61 10 U.S.C. § 1074g(a)(6) (2004).
62 Department of Defense Pharmacoeconomic Center. Cost Per 30 Day Equivalent Rx. May 1, 2007. https://rxportal.army.mil.
63 Ibid.
64 Ibid.
65 Nancy Gilbride and Steven B. Miller, Express Scripts. Brief to the Task Force. April 18, 2007.
66 RADM John McGinnis, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity, and CAPT Patricia Buss, Chair, DoD Pharmacy and Therapeutics Committee. Overview of the DoD Pharmacy Program. Brief to the Task Force. February 6, 2007.

In Fiscal Year 2006, the TRICARE pharmacy program filled 115 million prescriptions through 536 dispensing pharmacies at 121 MTFs, 58,650 pharmacies in the TRICARE network, and 1 mail order pharmacy, Express Scripts, Inc.[67]

Military Treatment Facility Pharmacies

Prescriptions may be filled (up to a 90-day supply for most medications) at an MTF pharmacy at no cost to the beneficiary if the medication is in the MTF formulary. Across the MHS, the 536 pharmacies located at the 121 MTFs dispensed 51 percent of the prescriptions filled in Fiscal Year 2006, for 25 percent of the total MHS pharmacy bill (see Figure 9).[68] With no copayment, the MTF pharmacy presents the best value to the beneficiary.

DoD DRUG EXPENDITURES THROUGH FY2006



Source: RADM John McGinnis, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity, and CAPT Patricia Buss, Chair, DoD Pharmacy and Therapeutics Committee. Overview of the DoD Pharmacy Program. Brief to the Task Force. February 6, 2007.

Figure 8

TRICARE Retail Pharmacy Program

TRRx is administered by Express Scripts, Inc. Beneficiaries in the continental United States and its territories may use the expanded, nationwide network of 58,650 retail pharmacies to fill prescriptions.[69] The retail portion of TRRx accounted for 35 percent of the workload in Fiscal Year 2006, amounting to 63 percent of the total MHS pharmacy bill (see Figure 9).[70] The mail order portion of TRRx accounted for 14 percent of the workload in FY 2006, amounting to 12 percent of the total MHS pharmacy bill (see Figure 8).

Non-Network Pharmacies

A non-network pharmacy is a retail pharmacy that is not part of the TRICARE network. Filling prescriptions at non-network pharmacies is the most expensive

67 Ibid.
68 Ibid.
69 Ibid.
70 Ibid.

option for the beneficiary. Beneficiaries may have to pay the total amount and then file a claim to receive partial reimbursement. Beneficiaries incur penalty fees if they are TRICARE Prime enrollees utilizing non-network pharmacies.

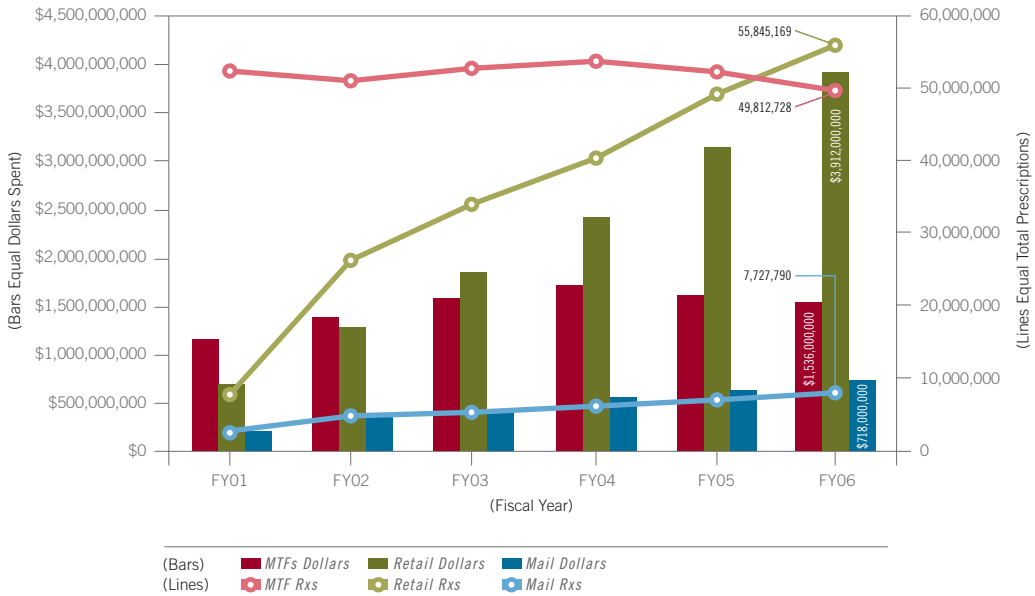
TRICARE Mail Order Pharmacy

TMOP also is administered by Express Scripts, Inc. To use TMOP, beneficiaries register by completing an online registration form.[71] Beneficiaries must then mail their health care provider's written prescription and the appropriate copayment to Express Scripts, Inc. New prescriptions may be faxed or phoned in by the provider. Within 10 to 14 days, the medications are sent directly to the beneficiary through the U.S. Postal Service. TMOP prescriptions accounted for 14 percent of prescriptions filled in Fiscal Year 2006, yet accounted for 12 percent of the total MHS pharmacy bill.[72]

The number of TRICARE-covered individuals has been growing, with steady growth in the last two years. Since the advent of TFL, pharmacy costs have been growing exponentially, with the retail network being the biggest cost driver (see Figure 9). The costs of drugs have been increasing rapidly overall. Express Scripts, Inc., has reported that "certain drugs had a higher level of cost growth in 2006, including medications to treat diabetes, which experienced a 15.5 percent growth, the second year of double-digit increases. In addition, the trend for expensive, but critically important specialty drugs rose 2.9 percent."[73]

TOTAL DRUG SPEND AND RX VOLUME

By Point of Service



Source: RADM John McGinnis, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity, and CAPT Patricia Buss, Chair, DoD Pharmacy and Therapeutics Committee. Overview of the DoD Pharmacy Program. Brief to the Task Force. February 6, 2007.

Figure 9

71 See www.express-scripts.com/TRICARE.
72 McGinnis and Buss, op. cit.
73 Federal Health Update, April 27, 2007. www.usminstitute.org/newsletter.html. Express Scripts Annual Drug Trends Report. www.express-scripts.com/ourcompany/news/industryreports/drugtrendreport/2006/dtrFinal.pdf.

In 2001, Congress expanded the pharmacy benefit for 1.8 million military retirees age 65 and older and their elderly dependents. Prior to 2001, this population could use the military prescription benefit at no cost only at MTF pharmacies. Under the new TSRx, retirees can use the TRICARE pharmacy benefit to obtain prescriptions through four sources: 1) MTF pharmacies, 2) retail pharmacies in the TRICARE network, 3) the TMOP, and 4) non-network retail pharmacies.

In 2005, DoD asked the RAND Center for Military Health Care Policy to assess factors contributing to the rising costs of prescription medications for military retirees and their families.[74] By examining TRICARE pharmacy claims data, RAND found that the majority of TSRx prescriptions still were being dispensed from MTFs; however, the amount dropped from 100 percent to 60 percent in the two years following the expansion of the benefit. There was a corresponding increase in the use of retail pharmacies.

RAND also found that:

- Because of higher prices to DoD, retail pharmacies account for the majority of pharmaceutical costs.
- Retail pharmacy use is related to the distance to the nearest MTF and to the nonavailability of certain drugs at MTFs.
- Implementing a three-tier drug benefit in the private sector slowed the increase in pharmaceutical spending.

RAND recommended that "to save costs without adversely affecting beneficiaries' health, DoD should carefully consider the drugs that it places in the more costly third-tier." RAND also recommended that to achieve greater overall health care cost savings, "DoD must assess the possible advantage of lowering the copayment for third-tier medications obtained from the TMOP, easing some of the prior authorization requirements at MTFs, and instituting other changes that would limit the incentive to use retail pharmacies."[75]

Mail Order Practices in the Private Sector

"Mail order pharmacy is the fastest growing segment of the retail pharmacy marketplace."[76] The average consumer is nearly 64 years old, and most are over 65. This is a group that tends to use multiple/maintenance medications for long-term, chronic conditions.[77] The civilian sector encourages, as does DoD, the use of mail order refills and provides a number of options for patients for this process, including phone, mail, and online refill ordering. For phone and online refills, the original prescriptions must be faxed by the provider. "Requiring mail order greatly increases its use: a recent study found that, on average, voluntary plans achieve 14 percent mail order use rates while mandatory plans increase use rates to 27 percent."[78]

A study (2002-2003) by the Virginia Commonwealth University was conducted based on claims data from approximately 100,000 members of a health plan. This plan afforded a 90-day supply of medications via mail order for the price of 2 30-day supplies from a community pharmacy. With more than 44,800 claims for the top 201 products dispensed by mail order, there was a 7.8 percent savings in total costs and a 12.8 percent copayment reduction, although total costs of the health plan continued to rise by 4.8 percent.[79,80]

---

74 Geoffrey Joyce, Jesse D. Malkin, and Jennifer Pace. Pharmacy Use and Costs in Employer-Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector. Santa Monica, Calif.: RAND Corporation, MG-154-OSD, 2005.
75 Ibid.
76 Michael Johnsrud. (2006). Will a Mandatory Mail Order Pharmacy Benefit Save Payers Money? Investigating the Evidence. www.nacdsfoundation.org/user-assets/Documents/PDF/Mail_Order_Pharmacy_Literature_Review_Manuscript_v2.pdf.
77 Ibid.
78 Ibid.
79 Managed Care Matters: Plan Member Response to Increase in Copays Varies by Therapeutic Class [Electronic Version]. Drug Benefit Trends. 2004;16(7):353-354.
80 Op cit., Johnsrud, p. 11.

The United Mine Workers of America (UMWA) Health and Retirements Funds is a health fund that covers approximately 51,000 retired union coal miners and their dependents. More than 50 percent of the beneficiaries are 80 years old or older (139 are more than 100 years old), and only 9 percent are under 55 years of age.[81] More than 80 percent of the fund's beneficiaries are Medicare eligible, with a median age of 78 years.

UMWA has two drug benefit plans administered through Caremark, Inc.: 1) the Combined Benefit Fund and the 1992 Benefit Plan and 2) the 1993 Benefit Plan. The pharmacy mail order portion of the plan has been very successful with those enrolled in the 1993 plan (which uses monetary incentives)—it has a 43 percent usage rate. The 1992 plan has virtually no monetary incentive and has very low usage.[82]

UMWA proactively engages in mail service promotion activities that have resulted in a mail service usage rate increase from 2 percent in January 2002 to 6 percent in September 2006.[83] Quarterly promotions are conducted, which consist of pension check stuffers, mailings, and electronic communications. Additionally, Call Center and Field Staff engage the beneficiaries using inbound calls as opportunities to discuss the benefits of using generics and mail services. Consequently, since January 2006 more than 2,300 prescriptions were transitioned to mail service.[84] The fund recently conducted a beneficiary outreach program to encourage the 1,000 users with the most maintenance medications filled by retail to switch to mail order. A targeted mailing was followed by telephonic outreach through which 50 percent of the 1,000 users were reached. Some 200 new prescriptions were started—a 3 percent improvement rate. A second phase of the outreach program began in April 2007.[85]

The lessons learned from UMWA are as follows:

- Mail order rates are improved by financial incentives and through targeted outreach in the absence of financial incentives.
- Communication involving frontline personnel helps to improve usage.
- Even small increases in the use of mail order services can result in significant savings.
- Mail order services must emulate those provided in the retail setting.[86]

Express Scripts, Inc., stated in its testimony to the Task Force that DoD potentially could save 3 percent or $617 million over three years if it implemented Exclusive Home Delivery and another $48 million if it implemented Home Delivery Education.[87] Table 6 displays the differentials for retail versus mail copayments among current and proposed DoD plans and Express Scripts.

---

81 Lorraine Lewis, Executive Director, UMWA, Health and Retirement Funds; Joel Kavet, Director, Managed Care Program Development and Research, UMWA Health and Retirement Funds; William Chisholm, Director of Operations, UMWA Health and Retirement Funds. Brief to the Task Force. Outreach Programs: Generics, Mail Order and other Healthcare Services, UMWA Health and Retirement Funds. April 18, 2007.
82 Ibid.
83 Ibid.
84 Ibid.
85 Ibid.
86 Ibid.
87 Nancy Gilbride and Steven B. Miller, Express Scripts. Brief to the Task Force. April 18, 2007.

Table 6: Express Scripts Copayment Design

	DOD CURRENT		EXPRESS SCRIPTS AVERAGE		DOD PROPOSED, FEB 07	
	Retail	Mail	Retail (30-day supply)	Mail (90-day supply)	Retail	Mail
Generic	$3	$3	$10	$20	$5	$0
Formulary Brand	$9	$9	$20	$40	$15	$15
Nonformulary Brand	$22	$22	$40	$80	NA	25%
Cost Share Percentage	9%		23%		17%	
Periodic Adjustments	Same structure for 6 years		Adjustments every 2–3 years			

Source: Nancy Gilbride and Steven B. Miller, Express Scripts. Brief to the Task Force. April 18, 2007.

In the Pharmaceutical Research and Manufacturers of America's (PhRMA's) testimony before the Task Force, it recommended that DoD should "encourage mail order but… not mandate it."[88] PhRMA pointed out that TRICARE's 7 percent mail order usage rate "pales in comparison to the usage of mail order in Medicare Part D and the commercial sector (which is over 20%)."[89] They suggested that DoD develop educational campaigns promoting awareness of the mail order option and that DoD work with prescribing providers to educate them about the mail order option for the TRICARE beneficiaries.[90] Noting that commercial plans have wider copayment differentials between mail order and retail points of service, PhRMA also recommended modification to the cost-sharing structure to increase the incentive to use mail order services.[91]

88 Christopher Singer, Executive Vice President and Chief Operating Officer, PhRMA; Richard Smith, Senior Vice President Policy Research and Strategic Planning, PhRMA; and Ann Leopold Kaplan, Assistant General Counsel, PhRMA. Brief to the Task Force on PhRMA. April 25, 2007.
89 Ibid.
90 Ibid.
91 Ibid.

Table 7 summarizes the pharmacy best practices presented to the Task Force.

Table 7: Proposed Pharmacy Best Practices

BEST BUSINESS PRACTICE	DESCRIPTION	IMPACT/ADVANTAGE	PROPOSED BY
Generic formulary medications	Encourage the use of generic and formulary medications at each point of service.	Every 1% increase in generic fill rates equates to a 1% reduction in pharmacy spending. A significant gap exists between actual and potential generic fill rates that if closed will lower cost.	Express Scripts
TRICARE mail order utilization	The use of mail order pharmacy services (TMOP) is convenient, safe, and less costly than retail.	Targets maintenance drugs only. Typical savings are $35 PMPY. Exclusive home delivery can save DoD 3% or $617 million dollars over 3 years.	Express Scripts PhRMA
Three-tier plan redesign	Three-tier plan design is an industry standard that allows cost increases from the lowest copay for generic brands to the highest copay for nonformulary brands. Copay structure is adjusted every 2-3 years in the commercial sector.	Encourages movement from high-cost nonformulary usage to less costly tiers.	Express Scripts PhRMA
Pharmacy mail service promotional activities	Beneficiary outreach program designed around live contacts and mailings with follow-up telephonic contact and tracking of outcomes.	Beneficiaries are clear regarding incentives. Encourages behavioral changes. Costs savings to the beneficiary and the organization once behavioral change experienced.	United Mine Workers Association
Competition model for retail point of service	Includes use of multiple PBMs to create competition and negotiations for rebates with manufacturers in exchange for preferred placement in the formulary.	Beneficiaries can choose among competing PBMs to select the one that best meets their health care needs. PBMs are incentivized to keep costs down and to allow broad beneficiary access to drugs. PBMs incentivized to increase enrollment by keeping costs down and access to drugs high.	PhRMA
Wellness initiatives and disease management	Wellness and disease management initiatives are those that encourage the use of and adherence to prescribed medications in conjunction with lifestyle changes.	Reduces comorbidities, hospitalizations, and deaths in the beneficiary population. Reduces overall health care costs.	PhRMA
Tier three drugs available exclusively at one point of service Note: Requires a regulation change	Tier three drugs are nonformulary drugs that patients elect to purchase through medical necessity. These drugs when used for maintenance could be filled by the mail order point of service.	Reduces cost for the beneficiary and for the Military Health System.	TMA Pharmaceutical Operations Directorate
Patient education at points of service	Interactions with a pharmacy provider is a venue through which patients can be provided with clinical drug counseling that will foster informed decisionmaking for choosing between high-cost brand names and generic drugs.	Improves adherence to medication regimen. Patients have the opportunity to evaluate point-of-service alternatives. May generate savings despite the lack of a generic alternative. Overall cost savings.	National Association of Chain Drug Stores

Pharmacy Procurement Issues

The Task Force also examined the contracting and procurement practices currently employed by DoD's pharmacy program.

According to testimony received by the Task Force from a representative of Medco, the company provided the following explanations for not submitting a proposal to the latest DoD Request for Proposals (RFP) for a single, "carved out" pharmacy benefit management program.[92] First, the RFP required Medco to purchase exclusively through DoD's national prime vendor at specified prices and to segregate that inventory from other inventory carried for Medco's large commercial home delivery business. Medco believed that this requirement to add more product lines would adversely affect its operational efficiencies. It uses a highly automated dispensing system with advanced robotics to process high-volume stock supplies, which Medco buys through vendors it selects. Second, the contract would require Medco to adopt and implement a new cost accounting system, an enterprise-wide investment for one customer (i.e., DoD) that may not be justified, depending on the duration of the customer relationship. Medco believed that its accounting practices, in accordance with Generally Accepted Accounting Principles, combined with DoD audits, were sufficient. Third, it believed that the RFP inhibited innovation, based on its assumption that innovations cited in the proposal would be subject to the quoted base price of the contract if awarded.

In its presentation to the Task Force, United HealthcareGroup raised a similar concern over its election not to submit a proposal to the most recent solicitation of proposals for the regional management care contracts, stating that it interpreted the RFP as requesting an "administrative" service provider rather than a partner to look at new initiatives, innovations, and the like.[93]

The current TRICARE Service managers also were generally critical of the DoD decision to carve out the Pharmacy Benefit Program (PBP) and place it under a single contractor.[94] They, as well as the current PBP Manager offered specific recommendations for improvement in the contracting process, which the Task Force will consider in preparing its final report. To a considerable extent, those inputs called for a framework that would provide more flexible and responsive adaptations to rapid changes in the health care industry such as emerging technologies and reduce constraints for incorporating best business practices.

---

92 Kenneth O. Klepper, President and Chief Operating Officer, Medco Health Solutions, Inc.; Jeffrey L. May, Senior Vice President, Drug Distribution and Control, Medco Health Solutions, Inc. Brief to the Task Force on Medco. April 18, 2007.
93 Jeannie Rivet, Executive Vice President, UnitedHealth Group. Brief to the Task Force. Trends and Value-Driven Health Care. March 7, 2007.
94 See presentations to the Task Force on March 28, 2007: Steven D. Tough, President, Health Net Federal Services; David J. Baker, President and Chief Executive Officer, Humana Military Healthcare Services; and Written Testimony of David J. McIntyre, President and CEO, TriWest Healthcare Alliance.

V Preliminary Findings and Recommendations

DoD analysts project that DoD health care costs will rise from $38 billion in 2006 to $64 billion in 2015, which translates to an increasing proportion of the DoD Total Obligation Authority from 8 percent to 12 percent. The increase in DoD's health care obligations places significant challenges before the defense health system.

In order to achieve even a modest reduction in the rate of growth, while preserving the generous benefit due to and earned by our Uniformed Service members and their families, DoD must pursue both the implementation of best business and management practices and the adjustment of financial incentives and cost shares.

Based on its deliberations thus far, the Task Force offers the following preliminary findings and recommendations relative to DoD health care costs in general and to cost-sharing and the pharmacy program in particular. These recommendations are designed to achieve greater efficiencies and cost savings while continuing to ensure quality health care and maintain readiness to provide health care services during war.

Recommendations are offered in the following areas: improving business and management practices; altering incentives in the pharmacy benefit; cost-sharing and realignment of fee structures; and ensuring that when applicable, TRICARE is the second payer.

Improving Business and Management Practices

The Task Force has begun to examine best practices in the public and private health care sectors that produce efficiencies, including improved financial controls and procurement practices and heightened awareness and greater use of mail order pharmacy services. These efficiencies will increase the cost-effectiveness of the military health care system.

In undertaking changes in practice or policy, pilot studies and/or demonstration projects should be used to assess the feasibility and cost-effectiveness of new ideas. These studies and projects can be accomplished more quickly than systemic changes that probably will require statutory changes.

1. Review the DoD Pharmacy Contract Process

Findings:

Current practices in the DoD pharmacy procurement process appear to pose obstacles to negotiating both best price and best use. Additionally, some have interpreted legal provisions governing beneficiary contact as prohibiting multiple targeted programs to increase home delivery that have been used successfully in the private sector. The last iteration of TRICARE Contracts (T-Nex) promoted a contract environment that focused on outcomes and best business practices. The Task Force heard from several current TRICARE contractors who spoke of their inability to implement their best business practices because of government regulations and/or strict interpretation of requirements.

Recommendation:

1.1 DoD should review its pharmacy acquisition strategies to determine if changes can be made to effect greater reductions in the cost of drugs and to foster improvements in effective utilization. In doing so, DoD should consider pursuing policy, regulatory, and/or statutory changes that would allow for alternative commercial best practices to be implemented when in the best interests of the government.

2. Conduct Eligibility Audits

Findings:

Audits of typical civilian health care plans have found that a substantial portion of payments are made for patients who are not eligible for care. While the percentage of erroneous payments may be small, the savings can be large, given the amount of expenditures. The Task Force did not see any evidence of extensive eligibility audits conducted by DoD or analyses of the accuracy of the Defense Enrollment Eligibility Reporting System (DEERS) personnel system in determining eligibility.

Recommendations:

2.1 An independent audit of TRICARE is necessary to determine the adequacy of control measures that ensure that only those who are eligible are receiving care.

2.2 An audit of DEERS accuracy is needed beyond simply verifying ID cards at the point of service for care.

Altering Incentives in the Pharmacy Benefit

The Task Force was briefed on best practices in the public and private sectors to control prescription drug costs, including the provision of incentives to increase generic prescription use and the use of mail order pharmacy services. The Task Force developed the following recommendations to lower future spending over what otherwise would have occurred.

3. Promote Mail Order and the Use of Generics

Findings:

Pharmacy services, including prescriptions filled at Military Treatment Facilities (MTFs) and outside of them, cost the DoD health care system $6.18 billion in 2006 and costs are expected to reach $15 billion by 2015, based on current trends. The Task Force heard convincing arguments that private sector plans have been able to reduce the growth in pharmacy costs while retaining clinical effectiveness by providing beneficiaries with greater incentives to utilize preferred drugs and fill maintenance prescriptions using mail order services. Generic drugs have the lowest copayment, followed by formulary drugs and nonformulary drugs. However, current DoD pharmacy copayment policies do not provide adequate incentives for patients to use the most cost-effective alternatives, such as the mail order pharmacy or an MTF. Employing financial incentives to encourage the use of the mail order pharmacy across all beneficiary groups should decrease retail pharmacy costs while preserving access to the local pharmacy.

Recommendations:

3.1 Copayments for prescriptions filled outside an MTF should be changed in order to alter incentives. DoD should increase the differentials in copayments to increase the use of more cost-effective practices. In its final report, the Task Force will make more specific recommendations about payment structure.

3.2 DoD should engage in an outreach program to publicize the value of using the TRICARE Mail Order Pharmacy (TMOP) program and generic drugs, utilizing the best practices followed by private companies in order to achieve savings.

Cost-Sharing and Realignment of Fee Structures

In recognition of the years of demanding service that military retirees have provided to the Nation, the Task Force believes that military retirees should receive health care benefits that are generous compared with U.S. public and private plans. Congress also has recognized this contribution. Much of the increase in the cost of DoD health care is attributed to explicit benefit expansion. Between 2000 and 2007, benefit expansion accounted for 64 percent of the increase in cost—57 percent for over-65 care and 7 percent for under-65 care.[95] However, when benefits have been expanded, it is not clear whether such expansions were implemented with an assessment of the impact that they would have on future costs or whether they were based on projections of the need for cost-sharing.

The Task Force believes that cost-sharing policies must be set in such a way that they are fair to America's taxpayers by ensuring the judicious use of scarce federal resources. The cost-sharing structure between the beneficiary and the government for health care services provided by the Military Health System (MHS) has remained unchanged, despite rapidly rising costs. Beneficiaries under the MHS incur far lower out-of-pocket costs than do their counterparts in the civilian sector for comparable care.

4. Increase the Share of Costs Borne by Beneficiaries

Findings:

According to DoD, since 1996, military health care premiums paid by individual military retirees under age 65 utilizing DoD's most popular plan (TRICARE Prime) have fallen from 11 to 4 percent when measured as a percentage of total health care costs.[96] By comparison, premiums for employer-provided plans in the civilian sector decreased slightly, from 28 percent in 1996 to 25 percent in 2006.[97] Federal civilian retirees pay out-of-pocket costs of about 25 percent of total costs in the Federal Employees Health Benefit Plan (FEHBP).[98]

Trends in out-of-pockets costs (which include premiums/enrollment fees, deductibles, and copayments) suggest the same pattern. Total out-of-pocket costs have risen much more slowly for military retirees than for civilian retirees. Specifically, for military retirees under 65 who are enrolled in TRICARE Prime, out-of-pocket costs rose 2.6 percent from 2003 to 2005, while out-of-pocket costs in civilian HMOs have risen 21.2 percent for the same period (TRICARE 2003: $727; 2005: $746—HMO 2003: $3,036; 2005: $3,681).[99]

A revised cost-sharing system would shift some costs, but more importantly, it could provide incentives for beneficiaries to change their behavior in ways that would slow the rate of cost growth. For example, revisions in cost-sharing may cause fewer retirees to drop private coverage in favor of TRICARE, and such revisions may foster more individual responsibility for wellness and preventive care.

---

95 John Kokulis, Special Assistant to the Assistant Secretary of Defense, Health Affairs, and Former Deputy Assistant Secretary of Defense, Health Affairs, Office of the Secretary of Defense. Sustaining the Military Health Benefit. Brief to the Task Force. January 16, 2007.
96 The Military Compensation System: Completing the Transition to an All-Volunteer Force. Report of the Defense Advisory Committee on Military Compensation. April 2006, p. 79.
97 Ibid.
98 FEHB law: Public Law 105-33, approved August 5, 1997.
99 Evaluation of the TRICARE Program. The Health Program Analysis and Evaluation Directorate, TRICARE Management Activity in the Office of the Assistant Secretary of Defense (Health Affairs). March 2006, p. 89.

Recommendations:

4.1 The portion of costs borne by beneficiaries should be increased to a level below that of the current FEHBP or that of generous private-sector plans and should be set at or below the level in effect in 1996. In its final report, the Task Force will recommend specific cost-sharing proposals and an accompanying set of enrollment fees and copayment levels.

4.2 Increases in cost-sharing should be phased in over three to five years to avoid precipitous changes. If Congress believes that increases in cost-sharing are too large relative to the amounts of retired pay, it should consider a one-time increase in military retired pay to offset part or all of the increase.

5. Index Premiums and Deductibles

Findings:

The Task Force notes that increases in medical inflation have, for some years, outpaced growth in overall inflation as measured by the Consumer Price Index. Even if Congress phases in an adjustment in cost-sharing for military retirees, as recommended above, the share gradually will fall unless actions are taken to index the costs borne by retirees.

Recommendations:

5.1 There should be an annual indexing of the premiums and deductibles paid by under-65 military retirees. In its final report, the Task Force will recommend a specific approach to indexing. In addition, periodic adjustment should be made to the catastrophic cap. These adjustments should avoid either frequent changes or increases that over time are excessively large.

5.2 Recommendation 5.1 will cause out-of-pocket costs for individual military retirees to rise more rapidly than their retired pay (which is increased annually based on the Consumer Price Index). All Americans face out-of-pocket health care costs that are rising faster than overall inflation. If Congress believes that retirees should not bear all of these added costs, it should periodically legislate special increases in retired pay to make up for some or all of the increases in the portion of retiree health care costs borne by individuals.

5.3 DoD should increase premiums and cost-sharing for under-65 military retirees so that the cost differential between TRICARE and private plans is smaller than it is currently. Premiums and deductibles should be indexed for increases on an annual basis according to an appropriate and widely acceptable index.

The Task Force has not yet had time to consider options for increasing or maintaining the use of private coverage. In its final report, it will explore a variety of potential strategies, for example:

- providing a stipend to employers to encourage a higher rate of use by employees who are eligible for TRICARE;
- providing a stipend to a health savings account to those who choose not to participate in TRICARE; and
- offering some form of supplemental coverage to under-65 retirees who retain their private health insurance and do not use TRICARE. This “TRIGAP” insurance would increase the incentive for retirees to maintain their private health care insurance. The coverage would be analogous to Medigap insurance and would be financed by DoD.

6. Tier the Payment Structure

Findings:

All military retirees, under age 65 or not otherwise Medicare-eligible, regardless of rank or retired compensation, pay the same individual or family enrollment fees. DoD has recommended that enrollment fees and deductibles vary in size based on an individual's pay grade at retirement, with higher-grade retirees paying larger amounts.

Recommendation:

6.1 Enrollment fees, deductibles, and copayments should be tailored to different circumstances, such as retired pay grade. However, further study is needed before proposing specific recommendations for variances in the beneficiary share of costs. In its final report, the Task Force will provide more specific recommendations.

Ensuring That TRICARE Is a Second Payer

7. Audit Compliance with TRICARE Law and Policy

Findings:

Although, under law, TRICARE is intended to be a second-payer system, insufficient data are available to conclude that it in fact is the second payer in all cases.

In addition, the National Defense Authorization Act of Fiscal Year 2001 expanded TRICARE benefits for eligible beneficiaries who are 65 and older and enrolled in Medicare Part B. Under TRICARE for Life, TRICARE becomes the second payer to Medicare for medical care that is a benefit under both Medicare and TRICARE.

The relatively small portion of TRICARE costs borne by individual retirees encourages retirees with access to private sector plans to drop their private coverage and rely on TRICARE as their primary plan. DoD estimates that approximately 72 percent of retirees under age 65 are working and have access to private sector health insurance.[100] "Among those with access to an employer health plan, 35 percent paid to enroll in TRICARE Prime and 62 percent sought care through some TRICARE option."[101] Thus, nearly two-thirds seek care through some type of TRICARE benefit.

Recommendation:

7.1 DoD should commission an independent audit to determine the level of compliance with law and policy regarding TRICARE as second payer.

Issues for Future Consideration

In the course of its deliberations, the Task Force identified several other issues relevant to cost-sharing and potential improved efficiencies in the MHS, including:

- recent proposals to reorganize military health care and increase the sharing of common services across DoD;
- strategies for modifying the pharmacy acquisition process to achieve greater savings and improved utilization; and
- the effects of the transition of the Guard and Reserve from a strategic force to an operational force—specifically the effects of mobilizations and demobilizations on beneficiaries as they access the healthcare system and on DoD healthcare costs.

In addition to refining its analyses of the issues presented in this report, the Task Force will further explore these topics as well as assess and make recommendations pertaining to the elements listed in its charge.

---

100 The Military Compensation System: Completing the Transition to an All-Volunteer Force. Report of the Defense Advisory Committee on Military Compensation. April 2006, p. 78.
101 Ibid.

Appendix A: Task Force Biographies

General John D.W. Corley (Co-Chair)
Vice Chief of Staff Headquarters, U.S. Air Force

General John D.W. Corley is Vice Chief of Staff, Headquarters, U.S. Air Force, a role in which he presides over the Air Staff and serves as a member of the Joint Chiefs of Staff Requirements Oversight Council. His previous staff positions comprise a mix of operational and joint duties in Tactical Air Command, Headquarters U.S. Air Force, and the Joint Staff. He received his B.S. in engineering from the U.S. Air Force Academy and earned his wings at Reese Air Force Base, Texas, in 1974. He earned an M.B.A. and another master's degree in national security and strategic studies. He also is a graduate of Harvard University's John F. Kennedy School of Government's Program for Senior Executives in National and International Security. General Corley has significant experience in intense combat, most recently during Operation Enduring Freedom. As Combined Air Operations Center Director, he directed the safe recovery of isolated personnel during the largest combat search-and-rescue mission in 50 years and was awarded the Bronze Star as a result. His aviation career includes more than 3,000 flying hours with a wide range of combat experience. He has commanded at the squadron, group, and wing levels. In addition to the Bronze Star, General Corley is a recipient of the Distinguished Service Medal, the Defense Superior Service Medal, the Legion of Merit, and the Defense Meritorious Service Medal, among other awards.

Gail R. Wilensky, Ph.D. (Co-Chair)
Senior Fellow, Project HOPE

Gail Wilensky is a Senior Fellow at Project HOPE, an international health education foundation, where she analyzes and develops policies relating to health reform and to ongoing changes in the medical marketplace. She testifies frequently before congressional committees, acts as an advisor to members of Congress and other elected officials, and speaks nationally and internationally before professional, business, and consumer groups. She is currently also a Commissioner on the President's Commission on the Care of Returning Wounded Warriors. From 2001 to 2003, she co-chaired the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, which addressed health care for both veterans and military retirees. From 1997 to 2001, she chaired the Medicare Payment Advisory Commission, which advises Congress on payment and other issues relating to Medicare, and from 1995 to 1997, she chaired the Physician Payment Review Commission. She also served as Deputy Assistant for Policy Development to President George H.W. Bush, advising him on health and welfare issues. Prior to assuming this position, she served as Administrator of the Health Care Financing Administration, overseeing the Medicare and Medicaid programs. Dr. Wilensky is an elected member of the Institute of Medicine and serves as a trustee of the Combined Benefits Fund of the United Mineworkers of America and the National Opinion Research Center. She is a former chair of the board of directors of Academy Health, a former trustee of the American Heart Association, and a current or former director of numerous other organizations. She also is a director on several corporate boards. Dr. Wilensky is the recipient of numerous honorary degrees and awards and has published more than 100 articles. She received a bachelor's degree in psychology and a Ph.D. in economics from the University of Michigan.

Major General Nancy Adams (Ret.)
Senior Partner, Martin, Blanck & Associates, Inc.

Nancy Adams joined Martin, Blanck & Associates in August 2005 after a distinguished career as both a military officer, retired in the rank of Major General, and a member of the Senior Executive Service (SES) in the federal government. She is one of Martin, Blank & Associates leading experts on federal health acquisition policies and procedures. In addition, she has extensive clinical, administrative, and senior management experience with large, complex government healthcare systems, and has demonstrated expertise and competency as an organizational leader, effective communicator, and resource manager with results that produced performance improvements. From 1998 through 2002, Major General Adams served as commanding general of Tripler Army Medical Center in Hawaii, a 266-bed tertiary care medical center employing 3000 personnel with a $245 million annual budget. She led the organization to a perfect 100% score on the survey by the Joint Commission on Accreditation of Healthcare Organizations. She also had responsibility for TRICARE Pacific, serving 527,960 beneficiaries in Hawaii and throughout the Pacific region. Prior to this command, she commanded William Beaumont Army Medical Center in El Paso, Texas, a 200-bed tertiary care medical center with 1800 personnel serving 400,000 beneficiaries. Brigadier General Adams served as the Chief of the Army Nurse Corps and Assistant Surgeon General of the Army for Personnel and Commander for the Center for Health Promotion and Preventive Medicine from 1991 to 1995. Prior to these leadership positions, she served in a variety of clinical nursing and nursing administration positions in the Army Medical Department and the Department of Defense.

Shay Assad
Director, Defense Procurement and Acquisition Policy

Mr. Shay Assad assumed his position as Director of Defense Procurement and Acquisition Policy (DPAP) on April 3, 2006. As the Director of DPAP, he is responsible for all acquisition and procurement policy matters in the Department of Defense (DoD). He serves as the principal advisor to the Under Secretary of Defense for Acquisition, Technology and Logistics, Deputy Under Secretary of Defense for Acquisition and Technology, and on the Defense Acquisition Board on acquisition/procurement strategies for all major weapon systems programs, major automated information systems programs, and services acquisitions. Mr. Assad is responsible for procurement/sourcing functional business process requirements in the department's business enterprise architecture and enterprise transition plan. In addition, Mr. Assad is DoD's advisor for competition, source selection, multiyear contracting, warranties, leasing, and all international contracting matters. Before assuming this position, Mr. Assad was the Assistant Deputy Commandant, Installations and Logistics (Contracts), at the Marine Corps Headquarters. Mr. Assad served two tours of duty aboard U.S. Navy destroyers and won recognition as Outstanding Junior Officer, Fifth Naval District. He then served as a Naval Procurement Officer at the Naval Sea Systems Command, where he was responsible for the negotiation and administration of the Aegis Weapons Systems engineering and production contracts. Between 1978 and 1994, Mr. Assad served in several increasingly responsible contract management positions for the Raytheon Company's largest electronics and missile divisions. In 1994, he was promoted to Vice President, Director of Contracts, for Raytheon and subsequently was promoted to Senior Vice President, Contracts in 1997. In 1998, he was promoted to Executive Vice President, served as the Chief Operating Officer, and subsequently served as the Chairman and Chief Executive Officer of Raytheon's engineering and construction business. Mr. Assad graduated with distinction from the U.S. Naval Academy.

Carolyn M. Clancy, M.D.
Director, Agency for Healthcare Research and Quality

Carolyn M. Clancy, M.D., was appointed Director of the Agency for Healthcare Research and Quality (AHRQ) on February 5, 2003. Prior to this appointment, Dr. Clancy served as AHRQ's Acting Director (from March 2002) and as director of the Agency's Center for Outcomes and Effectiveness Research (COER). Dr. Clancy holds an academic appointment at the George Washington University School of Medicine (Clinical Associate Professor, Department of Medicine) and serves as the Senior Associate Editor of Health Services Research. Dr. Clancy has served on multiple editorial boards—including those of the *Annals of Family Medicine*, the *American Journal of Medical Quality*, and *Medical Care Research and Review*—and has published widely in peer-reviewed journals. She also has edited or contributed to seven books. She is a member of the Institute of Medicine and was elected a Master of the American College of Physicians in 2004. Dr. Clancy, a general internist and health services researcher, is a graduate of Boston College and the University of Massachusetts Medical School. Following her clinical training, Dr. Clancy was a Henry J. Kaiser Family Foundation Fellow at the University of Pennsylvania. She was also an assistant professor in the Department of Internal Medicine at the Medical College of Virginia in Richmond before joining the staff of AHRQ in 1990.

Robert S. Galvin, M.D.
Director of Global Healthcare, General Electric Company

Robert Galvin, M.D., is Director of Global Healthcare for General Electric (GE). He oversees the design and performance of GE's health programs, which total over $ 3.0 billion annually, and is responsible for GE's medical services, encompassing over 220 medical clinics in more than 20 countries. Dr. Galvin completed his undergraduate work at the University of Pennsylvania, where he graduated magna cum laude and was elected to Phi Beta Kappa. He also received his M.D. degree at the University of Pennsylvania and was elected to Alpha Omega Alpha. He received an M.B.A. in health care management from Boston University's School of Management in 1995. In his current role, Dr. Galvin has focused on issues of market-based health policy and financing, with a special interest in quality measurement and improvement. He has been a leader in pushing for public release of performance information and reform of the payment system. Dr. Galvin is a founder of both the Leapfrog Group and Bridges to Excellence. He was a member of the Strategic Framework Board of the National Quality Forum and currently sits on the board of the National Committee for Quality Assurance and the Centers for Disease Control and Prevention's Director's Advisory Group on Emergency Preparedness. He has served on several Institute of Medicine Committees and is currently a Commissioner on the Commonwealth Fund's program on a High Performance Health System. Dr. Galvin's work has received awards from the National Health Care Purchasing Institute, the National Business Group on Health and the National Coalition for Cancer Survivorship. He is a Fellow of the American College of Physicians, and his work has been published in the *New England Journal of Medicine and Health Affairs*. He is Professor Adjunct of Medicine and Health Policy at Yale where he leads a seminar in the private sector at the School of Medicine and the M.B.A. program at the School of Management.

The Honorable Robert F. Hale
Executive Director, American Society of Military Comptrollers

Robert Hale currently is the Executive Director of the American Society of Military Comptrollers (ASMC). In that capacity, he runs an 18,000-member association that provides professional development opportunities to defense financial managers. His responsibilities include oversight of a large annual conference, a professional certification program, a quarterly journal, and many other activities. From 1994 to 2001, Mr. Hale was appointed by the President and confirmed by the Senate as Assistant Secretary of the Air Force (Financial Management and Comptroller). He was responsible for the Air Force budget and all aspects of Air Force financial management. Mr. Hale also served for 12 years as head of the defense unit of the Congressional Budget Office. His group provided defense analyses to Congress, and he frequently testified before congressional committees. Before coming to ASMC, Mr. Hale directed a program group at LMI Government Consulting and early in his career he served on Active Duty as a Navy officer and worked for the Center for Naval Analyses. Mr. Hale holds a B.S. and an M.S. from Stanford University and an M.B.A. from George Washington University. He is a Fellow of the National Academy of Public Administration and currently serves on the Defense Business Board. He is a Certified Defense Financial Manager.

The Honorable Robert J. Henke
Assistant Secretary for Management, Department of Veterans Affairs

Robert J. Henke was nominated by President George W. Bush to serve as Assistant Secretary for Management in the Department of Veterans Affairs (VA) and was sworn into office on November 3, 2005. In this position, he is responsible for the Department's budget (in excess of $87 billion requested for fiscal year 2008), financial policy and operations, acquisition and materiel management, real property asset management, and business oversight. He serves as VA's Chief Financial Officer, Chief Acquisitions Officer, and Senior Real Property Officer. Prior to his appointment, Mr. Henke served as the Principal Deputy under the Secretary of Defense (Comptroller) at the Department of Defense (DoD). In that capacity, he was the principal advisor to the DoD Comptroller/Chief Financial Officer, and his duties involved a broad range of financial management responsibilities, including development, justification, and execution of DoD's budget, and the formulation of DoD-wide financial and accounting policy. Mr. Henke served as a professional staff member with the U.S. Senate Committee on Appropriations, Subcommittee on Defense from 1999 to 2004, and as a Presidential Management Intern with the Office of the Assistant Secretary of the Navy (Financial Management and Comptroller) from 1997 to 1999. From 1993 to 1996, he was with General Electric Company, where he completed GE's Financial Management Program. A Reserve Navy officer, Mr. Henke graduated from the University of Notre Dame with a B.A. in government and international relations, and earned a Master's of Public Administration from Syracuse University's Maxwell School of Citizenship and Public Affairs.

Major General (Dr.) Joseph E. Kelley
Joint Staff Surgeon

Major General (Dr.) Joseph E. Kelley, U.S. Air Force, is Joint Staff Surgeon at the Pentagon. He serves as the chief medical adviser to the Chairman of the Joint Chiefs of Staff, providing advice to the Chairman, the Joint Staff, and Combatant Commanders. He also coordinates all issues related to operational medicine, force health protection, and readiness among the Combatant Command Surgeons, the Office of the Secretary of Defense, and the services. He is the appointed U.S. delegate to the NATO Council of Medical Directors. General Kelley has held academic appointments as clinical professor and assistant dean and is certified by the American Board of Surgery and is a distinguished graduate of the Aerospace

Medicine Primary Course. General Kelley graduated second in his class from the U.S. Air Force Academy. While at the Academy, he received the Surgeon General's award as the outstanding graduate in life sciences. He received his M.D. from Rush University Medical School and performed his residency in general surgery at David Grant Medical Center, Travis AFB, California. At Nellis AFB, Nevada, he served as a general surgeon and later as Chief of General Surgery. At Misawa Air Base, Japan, General Kelley served as Chief of Hospital Services, Chief of Surgery, and interim Chief of Aerospace Medicine. He was reassigned as Commander of the 90th Strategic Hospital, Francis E. Warren AFB, Wyoming, and after his service there was selected as the Strategic Air Command's Outstanding Medical Leader. As Commander of the 857th Strategic Hospital, Minot AFB, North Dakota, General Kelley is the only individual to win the Strategic Air Command's Medical Leadership Award for a second time. He commanded the Ehrling Berquist Hospital at Offutt AFB, Nebraska, served as Chief of Medical Resources in the Office of the Surgeon General, and was Command Surgeon for Pacific Air Forces. As Commander of Wright-Patterson Medical Center, Wright-Patterson AFB, Ohio, and Lead Agent, Department of Defense Health Region 5, he led a unit that received Defense Department awards for patient satisfaction and access, as well as a Commander Installation Excellence Unit Award. Prior to assuming his current position, he was Assistant Surgeon General for Healthcare Operations, Office of the Surgeon General. General Kelly is certified by the American Board of Surgery.

Lawrence S. Lewin
Executive Consultant, Washington, D.C.

Larry Lewin founded the Lewin Group in 1970 and remained its president and CEO through three acquisitions until 1999. He has directed a wide range of projects in health policy and finance, academic medicine, public and private health insurance, technology and market assessment of medical devices and pharmaceutical products, strategic visioning and planning, and health systems management and governance. He has conducted nearly 100 workshops and strategic planning conferences for a wide variety of health care executives and organizations. He left the Lewin Group in December 1999 and currently, as an executive consultant, is assisting senior healthcare executives, foundations, and organizations in strategic decisionmaking, program improvement, and executive coaching. Recently, he has focused his attention on clinical and technology effectiveness, health promotion, and the challenge of managing collaborative organizations and programs in both the academic and clinical realms. Mr. Lewin serves on a number of corporate boards including those of CardioNet, H&Q Healthcare and Life Sciences Funds, and Medco Health Solutions. He also serves on the Intermountain Healthcare Board of Trustees (since 1984) and has chaired its Information Systems Board Committee (since1993). He was elected to the Institute of Medicine (IOM)/National Academies in 1984, served eight years as an elected member of the IOM Council, and in 2004 was awarded the IOM's Adam Yarmolinsky Medal for Distinguished Service. He was a founding member of the Association for Health Services Research (now Academy Health) and is currently a member of the National Commission on Prevention Priorities. Mr. Lewin holds an A.B. from Princeton University's Woodrow Wilson School of Public and International Affairs and an M.B.A. from the Harvard Business School, where he was a Baker Scholar. Mr. Lewin proudly served as an officer in the U.S. Marine Corps.

Rear Admiral John M. Mateczun, M.D.
Senior Health Care Executive

Rear Admiral John M. Mateczun is Deputy Surgeon General of the Navy and Vice Chief, Bureau of Medicine and Surgery. He also serves as Director of the Military Health System Office of Transformation. Admiral Mateczun began his career of service as an enlisted member of the U.S. Army and trained at the Explosive Ordnance Disposal School at Indian Head, Maryland. He served two tours of duty in Vietnam and later received a Doctor of Medicine degree from the University of New Mexico. He completed training in psychiatry at the Naval Regional Medical Center, Oakland, California and also received a Master's of Public Health degree from the University of California, Berkeley. Admiral Mateczun was assigned as Division Psychiatrist and Assistant Division Surgeon, 3d Marine Division, Okinawa, Japan. He was then assigned to the Naval Hospital, Bethesda, Maryland as a staff physician, where he became the Intern Advisor and Transitional Intern Program Director. He also has completed requirements for a law degree at Georgetown University Law Center. He became Chairman of Psychiatry at Naval Hospital Portsmouth and then at the National Naval Medical Center where he became the Acting Director of Medical Services during Operation Desert Shield. During Operation Desert Storm he was assigned to I Marine Expeditionary Force in Saudi Arabia as a consultant on the establishment and operation of Combat Stress Centers. He was a medical crew member on the first flight that retrieved repatriating Prisoners of War in Amman, Jordan. Returning to Bethesda, he was appointed Director of Medical Services and then was assigned as the Force Surgeon for Marine Forces Pacific. He was the first Chief of Staff at TRICARE Region 1 and then appointed Principal Director for Clinical Services under the Assistant Secretary of Defense for Health Affairs. Subsequent to that tour he commanded the Naval Hospital, Charleston, South Carolina. Selected for promotion to flag rank he headed Navy medical operations and was then selected to be the Joint Staff Surgeon and Medical Advisor to the Chairman of the Joint Chiefs of Staff. He was the United States delegate to the NATO Committee of Chiefs of Medical Services. He was present in the Pentagon on 9/11/01 and subsequently served on the Joint Staff during Operations Noble Eagle, Enduring Freedom, and Iraqi Freedom. Admiral Mateczun was subsequently the Chief of Staff and Program Executive Officer at the Bureau of Medicine and Surgery. Admiral Mateczun was selected for promotion to Rear Admiral and assumed command of the Naval Medical Center, San Diego, the military's largest Medical Center employing 6,200 military, civilians, and contractors with an operating budget of $380 million. Under his leadership, Naval Medical Center, San Diego deployed over 1,000 personnel in support of Operations Iraqi Freedom, Enduring Freedom, and Unified Assistance. Admiral Mateczun is board certified in adult psychiatry and forensic psychiatry. His awards include the Navy Distinguished Service Medal, Defense Superior Service Medal with Oak Leaf Cluster, Legion of Merit with two Gold Stars, Bronze Star, Defense Meritorious Service Medal, Meritorious Service Medal with Gold Star, Navy/Marine Corps Commendation Medal, Army Commendation Medal, and Navy/Marine Corps Achievement Medal.

General Richard B. Myers (Ret.)
Former Chairman, Joint Chiefs of Staff

Retired U.S. Air Force General Richard B. Myers served as the 15th Chairman of the Joint Chiefs of Staff, the U.S. military's highest ranking officer, from 2001 to 2005. In this capacity, he served as the principal military advisor to the President, the Secretary of Defense, and the National Security Council. He previously served as Vice Chairman of the Joint Chiefs of Staff, a role in which he served as the Chairman of the Joint Requirements Oversight Council, Vice Chairman of the Defense Acquisition Board, and member of the National Security Council Deputies Committee and the Nuclear Weapons Council. General Myers entered the Air Force in 1965 through the Reserve Officer Training Corps program. His

career includes operational command and leadership positions in a variety of Air Force and Joint assignments. General Myers is a command pilot with more than 4,100 flying hours. As the Vice Chairman from March 2000 to September 2001, General Myers served as the Chairman of the Joint Requirements Oversight Council, Vice Chairman of the Defense Acquisition Board, and as a member of the National Security Council Deputies Committee and the Nuclear Weapons Council. In addition, he acted for the Chairman in all aspects of the planning, programming, and budgeting system including participation in the Defense Resources Board. From 1998 to 2000, General Myers was Commander in Chief of the North American Aerospace Defense Command and U.S. Space Command; Commander, Air Force Space Command; and Department of Defense manager, space transportation system contingency support at Peterson Air Force Base, Colorado. As commander, General Myers was responsible for defending America through space and intercontinental ballistic missile operations. Prior to assuming that position, from 1997 to 1998, he was Commander of the Pacific Air Forces, Hickam Air Force Base, Hawaii; from 1996 to 1997, he was Assistant to the Chairman of the Joint Chiefs of Staff; and from 1993 to 1996 was Commander of U.S. Forces Japan and 5th Air Force at Yokota Air Base, Japan. He is a graduate of Kansas State University and received a master's degree in business administration from Auburn University. The General has attended the Air Command and Staff College at Maxwell Air Force Base, Alabama; the U.S. Army War College at Carlisle Barracks, Pennsylvania; and the Program for Senior Executives in National and International Security at Harvard's John F. Kennedy School of Government.

Lt. Gen. (Dr.) James G. Roudebush
Surgeon General of the Air Force, Headquarters U.S. Air Force

Lieutenant General (Dr.) James G. Roudebush is the Surgeon General of the Air Force, a role in which he serves as functional manager of the U.S. Air Force Medical Service. He advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs, on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force staff. General Roudebush has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs, and procedures to support worldwide medical service missions. He exercises direction, guidance, and technical management of more than 42,400 people assigned to 74 medical facilities worldwide. Before his selection as the 19th Surgeon General, he served as the Deputy Surgeon General of the U.S. Air Force, and before becoming Deputy Surgeon General, he served as Command Surgeon for U.S. Central Command, Pacific Air Forces, U.S. Transportation Command and Headquarters Air Mobility Command. He completed residency training in family practice at the Wright-Patterson Air Force Medical Center, Ohio, in 1978, and aerospace medicine at Brooks Air Force Base, Texas, in 1984. The General commanded a wing clinic and wing hospital before becoming Deputy Commander of the Air Force Materiel Command Human Systems Center. General Roudebush entered the Air Force in 1975 after receiving a Bachelor of Medicine degree from the University of Nebraska at Lincoln, and a Doctor of Medicine degree from the University of the Nebraska College of Medicine.

Major General Robert W. Smith III (Ret.)
U.S. Army Reserve

Major General Robert W. Smith III, U.S. Army Reserve (Retired) served as President of the Reserve Officers Association from July 2005 to July 2006 and continues to serve on the association's Executive Committee as the Immediate Past President. General Smith retired from the Army after 34 years active and reserve commissioned service. He is a former air defense and infantry officer who commanded from detachment to division level and served in many key staff positions at numerous levels of the Army. A Vietnam War combat veteran, General Smith has been decorated with the Distinguished Service Medal, the Legion of Merit, the Bronze Star with Oak Leaf Cluster, and the Meritorious Service Medal with two Oak Leaf Clusters, and other awards. General Smith also is a retired Ford Motor Company finance executive with 32 years of service. During his career with Ford, General Smith held a number of financial and managerial positions, including Manager for Sarbanes-Oxley compliance testing and eight years as the Global Controller, Service Engineering Office. General Smith has served as CEO of Two Star Strategic Services, a business and professional consulting firm in West Bloomfield, Michigan; as General Partner with Smith and Jones Enterprises; and as a member of the board of directors of Volunteers of America, State of Michigan. He was also the Vice Chair of the Pentagon Federal Credit Union Foundation Board, Arlington, Virginia, a group that helps returning wounded soldiers and all soldiers with financial management. He has been featured as the cover of *Fortune* magazine and profiled in the *Wall Street Journal*. General Smith's other memberships include the Association of the U.S. Army, Sigma Pi Phi Fraternity, Kappa Alpha Psi Fraternity, National Black MBA Association, and the Sovereign Military Order of the Temple of Jerusalem. He earned a master's degree in business administration from the University of Pittsburgh Katz Business School and is the recipient of an honorary Doctor of Humane Letters from Florida A & M University.

Appendix B: Authorizing Language and Charge to the Task Force

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR OF 2007
109th Congress, Public Law 109-364

SEC. 711. DEPARTMENT OF DEFENSE TASK FORCE ON THE FUTURE OF MILITARY HEALTH CARE.

(a) REQUIREMENT TO ESTABLISH—The Secretary of Defense shall establish within the Department of Defense a task force to examine matters relating to the future of military health care.

(b) COMPOSITION—

(1) MEMBERS—The task force shall consist of not more than 14 members appointed by the Secretary of Defense from among individuals described in paragraph (2) who have demonstrated expertise in the area of health care programs and costs.

(2) RANGE OF MEMBERS.—The individuals appointed to the task force shall include—

(A) at least one member of each of the Medical Departments of the Army, Navy, and Air Force;

(B) a number of persons from outside the Department of Defense equal to the total number of personnel from within the Department of Defense (whether members of the Armed Forces or civilian personnel) who are appointed to the task force;

(C) persons who have experience in—

(i) health care actuarial forecasting;

(ii) health care program and budget development;

(iii) health care information technology;

(iv) health care performance measurement;

(v) health care quality improvement including evidence-based medicine; and

(vi) women's health;

(D) the senior medical advisor to the Chairman of the Joint Chiefs of Staff;

(E) the Director of Defense Procurement and Acquisition Policy in the Office of the Under Secretary of Defense for Acquisition, Technology, and Logistics;

(F) at least one member from the Defense Business Board;

(G) at least one representative from an organization that advocates on behalf of active duty and retired members of the Armed Forces who has experience in health care; and

(H) at least one member from the Institute of Medicine.

(3) INDIVIDUALS APPOINTED OUTSIDE THE DEPARTMENT OF DEFENSE—

(A) Individuals appointed to the task force from outside the Department of Defense may include officers or employees of other departments or agencies of the Federal Government, officers or employees of State and local governments, or individuals from the private sector.

(B) Individuals appointed to the task force from outside the Department of Defense shall include—

(i) an officer or employee of the Department of Veterans Affairs; and

(ii) an officer or employee of the Department of Health and Human Services.

(4) DEADLINE FOR APPOINTMENT—All appointments of individuals to the task force shall be made not later than 90 days after the date of the enactment of this Act.

(5) CO-CHAIRS OF TASK FORCE.—There shall be two cochairs of the task force. One of the co-chairs shall be designated by the Secretary of Defense at the time of appointment from among the Department of Defense personnel appointed to the task force. The other co-chair shall be selected from among the members appointed from outside the Department of Defense by members so appointed.

(c) ASSESSMENT AND RECOMMENDATIONS ON THE FUTURE OF MILITARY HEALTH CARE.—

(1) IN GENERAL—Not later than 12 months after the date on which all members of the task force have been appointed, the task force shall submit to the Secretary a report containing Reports containing an assessment of, and recommendations for, sustaining the military health care services being provided to members of the Armed Forces, retirees, and their families.

(2) UTILIZATION OF OTHER EFFORTS—In preparing the report, the task force shall take into consideration the findings and recommendations included in the Healthcare for Military Retirees Task Group of the Defense Business Board, previous Government Accountability Office reports, studies and reviews by the Assistant Secretary of Defense for Health Affairs, and any other studies or research conducted by organizations regarding program and organizational improvements to the military health care system.

(3) ELEMENTS—The assessment and recommendations (including recommendations for legislative or administrative action) shall include measures to address the following:

(A) Wellness initiatives and disease management programs of the Department of Defense, including health risk tracking and the use of rewards for wellness.

(B) Education programs focused on prevention awareness and patient-initiated health care.

(C) The ability to account for the true and accurate cost of health care in the military health system.

(D) Alternative health care initiatives to manage patient behavior and costs, including options and costs and benefits of a universal enrollment system for all TRICARE users.

(E) The appropriate command and control structure within the Department of Defense and the Armed Forces to manage the military health system.

(F) The adequacy of the military health care procurement system, including methods to streamline existing procurement activities.

(G) The appropriate mix of military and civilian personnel to meet future readiness and high-quality health care service requirements.

(H) The beneficiary and Government cost-sharing structure required to sustain military health benefits over the long term.

(I) Programs focused on managing the health care needs of Medicare-eligible military beneficiaries.

(J) Efficient and cost effective contracts for health care support and staffing services, including performance-based requirements for health care provider reimbursement.

(d) ADMINISTRATIVE MATTERS—

(1) COMPENSATION—Each member of the task force who is a member of the Armed Forces or a civilian officer or employee of the United States shall serve without compensation (other than compensation to which entitled as a member of the Armed Forces or an officer or employee of the United States, as the case may be). Other members of the task force shall be treated for purposes of section 3161 of title 5, United States Code, as having been appointed under subsection (b) of such section.

(2) OVERSIGHT—The Under Secretary of Defense for Personnel and Readiness shall oversee the activities of the task force.

(3) ADMINISTRATIVE SUPPORT—The Washington Headquarters Services of the Department of Defense shall provide the task force with personnel, facilities, and other administrative support as necessary for the performance of the duties of the task force.

(4) ACCESS TO FACILITIES—The Under Secretary of Defense for Personnel and Readiness shall, in coordination with the Secretaries of the military departments, ensure appropriate access by the task force to military installations and facilities for purposes of the discharge of the duties of the task force.

(e) REPORTS—

(1) INTERIM REPORT—Not later than May 31, 2007, the task force shall submit to the Secretary of Defense and the Committees on Armed Services of the Senate and the House of Representatives an interim report on the activities of the task force. At a minimum, the report shall include interim findings and recommendations regarding subsection (c)(3)(H), particularly with regard to cost-sharing under the pharmacy benefits program.

(2) FINAL REPORT—

(A) The task force shall submit to the Secretary of Defense a final report on its activities under this section. The report shall include—

(i) a description of the activities of the task force;

(ii) the assessment and recommendations required by subsection (c); and

(iii) such other matters relating to the activities of the task force that the task force considers appropriate.

(B) Not later than 90 days after receipt of the report under subparagraph (A), the Secretary shall transmit the report to the Committees on Armed Services of the Senate and the House of Representatives. The Secretary may include in the transmittal such comments on the report as the Secretary considers appropriate.

(f) TERMINATION—The task force shall terminate 90 days after the date on which the final report of the task force is transmitted to Congress under subsection (e)(2).

Appendix C: Meetings and Presentations

January 16, 2007
Arlington, Virginia

Allen Middleton, Acting Deputy Assistant Secretary of Defense for Health Affairs and Acting Chief Financial Officer, TRICARE Management Activity. Overview of Military Health Care System and Defense Health Program.

John L. Kokulis, Special Assistant to the Assistant Secretary of Defense for Health Affairs. Sustaining the Benefit.

Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs. Comments.

Dr. David Chu, Under Secretary of Defense for Personnel and Readiness. Comments.

February 6, 2007
Washington, D.C.

Major General Robert Smith, U.S. Army Reserve (Ret.), Task Force Member. Presentation: *Back Brief on Meeting with Advocacy Groups*.

Jean Storck, Chief, Health Plan Operations, TRICARE Management Activity, Office of the Assistant Secretary of Defense for Health Affairs. Presentation: *TRICARE Contracts Overview*.

Rear Admiral Thomas J. McGinnis, U.S. Public Health Service, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity, Office of the Assistant Secretary of Defense for Health Affairs. Presentation: *Overview of the DoD Pharmacy Program*.

Captain Patricia Buss, Medical Corps, U.S. Navy, Chair, DoD Pharmacy and Therapeutics Committee. Presentation: *Overview of the DoD Pharmacy Program*.

February 20, 2007
Washington, D.C.

Lieutenant General Kevin C. Kiley, Surgeon General, U.S. Army and Commanding General, Army Medical Command. Presentation: *Army Surgeon General Brief*.

Vice Admiral Donald Arthur, Surgeon General, U.S. Navy and Chief, Navy Bureau of Medicine and Surgery. Presentation: *Navy Medicine*.

Major General C. Bruce Green, Deputy Surgeon General, U.S. Air Force. Presentation: *Air Force Medical Service 2007*.

Major General Joseph Kelley, Joint Staff Surgeon, the Joint Staff. Presentation: *Joint Staff Surgeon Briefing*.

March 7, 2007
Washington, D.C.

Joseph L. Barnes, National Executive Secretary, Fleet Reserve Association and Co-Chairman, the Military Coalition. Submitted written statement for the record.

Colonel Steven Strobridge, United States Air Force (Ret.), Director, Government Relations, Military Officers Association of America (MOAA); and Co-Chairman, the Military Coalition. Submitted written statement for the record.

Joyce Raezer, Chief Operating Officer, National Military Family Association, presented on behalf of the National Military Family Association. Submitted written statement for the record.

Deirdre Parke Hollomon, Legislative Director, the Retired Enlisted Association, presented on behalf of the Retired Enlisted Association. Submitted written statement for the record.

Rick Jones, Legislative Director, National Association for Uniformed Services, presented on behalf of the National Association for the Uniformed Services. Submitted written statement for the record.

Captain Michael Smith, U.S. Navy Reserve (Ret.), National President, Reserve Officers Association of the United States, presented on behalf of the Reserve Officer's Association. Submitted written statement for the record.

Michael H. Wysong, Director, National Security and Foreign Affairs, Veterans of Foreign Wars of the United States. Written Statement for the record.

D. Michael Duggan, Deputy Director, National Security Commission, the American Legion. Written Statement for the record.

The Naval Reserve Association. Written Statement for the record.

Mary Ann Wagner, Registered Pharmacist, Senior Vice President Policy and Pharmacy Regulatory Affairs, National Association of Chain Drug Stores (NACDS). Presentation: *National Association of Chain Drug Stores*.

Julie Khani, Vice President, Federal Health Programs, NACDS. Presentation: *National Association of Chain Drug Stores*.

Debbie Garza, Registered Pharmacist, Director, Government and Community Relations, Walgreen Company. Presentation: *National Association of Chain Drug Stores*.

Jeannie Rivet, Executive Vice President, UnitedHealth Group. Presentation: *Trends and Value-Driven Health Care*.

March 28, 2007
Washington, D.C.

Steve D. Tough, President, Health Net Federal Services. Presentation: *Health Net*.

David J. Baker, President and Chief Executive Officer, Humana Military Health-care Services (HMHS). Presentation: *Humana*.

David J. McIntyre, Jr , President and Chief Executive Officer, TriWest Healthcare Alliance. Presentation: *TriWest*.

April 9, 2007
San Antonio, Texas

Town Hall Meeting-Open to Public, Sam Houston Club, Fort Sam Houston.

April 10, 2007
San Antonio, Texas

Spouse Panel

Diane Rohrbough, U.S. Air Force (spouse was in the Medical Service Corps)
Elizabeth Radke, U.S. Navy Veteran (spouse is Active Duty Marine)
Kathy Shaffer, U.S. Air Force (spouse of retired Brigadier General)
Elizabeth Medley, U.S. Air Force, (spouse of U.S. Air Force physician)

Enlisted Panel

Sergeant Emily Little, U.S. Army
Sergeant First Class Santos Alonzo, U.S. Army
Senior Master Sergeant Douglas Onwiler, U.S. Air Force
Staff Sergeant Marilyn Clayton, U.S. Air Force
Master at Arms 1st Class Linda Coakely, U.S. Navy
Sergeant Chad Rozanski, U.S. Army

Guard and Reserve Panel

Lieutenant Colonel Grant Olbrich, U.S. Marine Corps
Sergeant First Class Santos Lopez, U.S. Army
Hospital Corpsman 2nd Class Gary Ard, U.S. Navy
Aviation Machinist's Mate 2nd Class Eric Mickett, U.S. Navy
Master Sergeant David Smith, 149 FW (ANG) U.S. Air Force
Major Mark Goldstein, U.S. Air Force Reserve

Officer Panel

Captain Jerome Smith, U.S. Army, Captain, Signal Corps.
First Lieutenant Sean Thomas, U.S. Army.
Lieutenant Suzanne J. Wood, U.S. Navy.
Captain Regina O. Samuel, U.S. Air Force.
Major Robb J. Passinault, U.S. Air Force.
Lieutenant Commander Joseph P. Lawrence, U.S. Navy, DoD Pharmacoeconomic Center.

Retired Panel

Major General Herbert Emanuel, U.S. Air Force (Ret.), former Executive Vice President of USAA (United Services Automobile Association).
Colonel Homer Lear, U.S. Air Force (Ret.), Texas Silver Haired Legislature.
Major General Thomas P. Ball Jr., M.D., U.S. Air Force (Ret.). Currently, Chief of Urology and Director of Residency Program, University of Texas Health Science Center.
Brigadier General Patrick O. Adams, U.S. Air Force (Ret.). Currently, Vice President, Human Capital Solutions.
Major General Harold Timboe, M.D., U.S. Army (Ret). Currently, Associate Vice President for Research, University of Texas Health Science Center.

April 18, 2007
Washington, D.C.

David M. Walker, Comptroller General of the United States, Government Accountability Office (GAO). Presentation: *DoD's 21st Century Health Care Spending Challenges*.

Kenneth O. Klepper, President and Chief Operating Officer, Medco Health Solutions, Inc. Presentation: *Medco*.

Jeffrey L. May, Senior Vice President, Drug Distribution and Control, Medco Health Solutions, Inc. Presentation: *Medco*.

Lorraine Lewis, Executive Director, United Mine Workers of America, Health and Retirement Funds. Presentation: *Outreach Programs: Generics, Mail Order and other Healthcare Services*.

Dr. Joel Kavet, Director, Managed Care Program Development and Research, United Mine Workers of America Health and Retirement Funds. Presentation: *Outreach Programs: Generics, Mail Order and other Healthcare Services*.

William Chisholm, Director of Operations, United Mine Workers of America Health and Retirement Funds. Presentation: *Outreach Programs: Generics, Mail Order and other Healthcare Services*.

Joan Hunter Veal, Senior Manager, Pharmacy Programs, United Mine Workers of America Health and Retirement Funds. Presentation: *Outreach Programs: Generics, Mail Order and other Healthcare Services*.

Dr. Peter B. Collins, Medical Director, United Mine Workers of America Health and Retirement Funds. Presentation: *Outreach Programs: Generics, Mail Order and other Healthcare Services*.

Nancy Gilbride, Vice President and General Manager, TRICARE Pharmacy Division, Express Scripts. Presentation: *Express Scripts*.

Dr. Steven B. Miller, Chief Medical Officer, Express Scripts, Inc. and CuraScript. Presentation: *Express Scripts*.

April 25, 2007
Washington, D.C.

Christopher Singer, Executive Vice President and Chief Operating Officer, PhRMA (Pharmaceutical Research and Manufacturers of America). Presentation: *PhRMA*.

Richard Smith, Senior Vice President Policy Research and Strategic Planning, PhRMA. Presentation: *PhRMA*.

Ann Leopold Kaplan, Assistant General Counsel, PhRMA. Presentation: *PhRMA*.

Edward, L. Allen, Vice President, Coalition for Government Procurement. Presentation: *The Coalition for Government Procurement*.

Donna Yesner, Esq. Partner, McKenna, Long, and Aldridge, LLC. Presentation: *The Coalition for Government Procurement*.

Appendix D: Recommendations of Previous Review Groups

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING	PAGE
Defense Business Board	Report FY05-4	Report to Secretary of Defense: Healthcare for Military Retirees	Dec 05	Managing Pharmacy costs—driving incentives toward generics and disease-management-driven formularies are key to savings.	A–8
Defense Business Board	Report FY05-4	Report to Secretary of Defense: Healthcare for Military Retirees	Dec 05	Index existing client participation to industry deductibles, copayments, and premiums.	4, A–11, B-11
Defense Business Board	Report FY05-4	Report to Secretary of Defense: Healthcare for Military Retirees	Dec 05	Enhance dialogue between VA and the Military Health System (MHS) to achieve scale economics/market power for the Pharmacy benefits.	A–13
Defense Business Board	Report FY05-4	Report to Secretary of Defense: Healthcare for Military Retirees	Dec 05	Managing Pharmacy costs—IT systems used by physicians for delivery of care; plan incentives are designed to drive doctors/ patients toward OTC medicines, genericism, and disease management-driven formularies.	B–7
Defense Business Board	Report FY05-4	Report to Secretary of Defense: Healthcare for Military Retirees	Dec 05	Provide individuals with easy-to-use/ understand comprehensive health decision tools to optimize medical visits, and encourage use of generic pharmaceuticals toward decreasing provider and individual costs.	B–11
GAO	GAO-05-555	Mail Order Pharmacies: DoD's Use of VA's Mail Pharmacy Could Produce Savings and Other Benefits	June 05	DoD could achieve savings if it used VA's Consolidated Mail Outpatient Pharmacy (CMOP) program to dispense refill prescriptions by taking advantage of VA's generally lower drug prices.	3
RAND	RB9084	Pharmacy Benefits for Military Retirees: Controlling Costs Without Compromising Health	2005	The majority of pharmaceutical costs are incurred from drugs obtained at retail pharmacies, because the cost of those drugs to DoD is higher than the cost of the same drugs dispensed from a Military Treatment Facility (MTF) or a mail-order pharmacy. Thus, DoD costs could decrease if retirees shifted from retail pharmacies to military facilities or the TRICARE Mail Order Pharmacy (TMOP) program.	2
RAND	RB9084	Pharmacy Benefits for Military Retirees: Controlling Costs Without Compromising Health	2005	Analysis of health insurance data from large private employers shows that implementing a three-tier drug benefit in the military health system could slow the rate of increase in spending on pharmaceuticals.	2
RAND	RB9084	Pharmacy Benefits for Military Retirees: Controlling Costs Without Compromising Health	2005	To achieve the significant cost savings suggested in this study without adversely affecting the health status of beneficiaries, DoD should carefully consider the drugs and drug classes that it places in the more costly third tier.	2

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING	PAGE
GAO	GAO-02-969T	VA AND DoD HEALTH CARE: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges	July 22, 2002	"We identified four factors that have contributed to VA's and DoD's success in reducing pharmacy costs: • Formularies to substitute cost-effective drugs • Different types of purchasing arrangements to secure lower prices • Mail-order dispensing to refill prescriptions • Joint purchasing of prescription drugs to leverage purchasing power"	3
GAO	GAO-02-969T	VA AND DoD HEALTH CARE: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges	July 22, 2002	VA and DoD face continuing challenges as pharmacy cost pressures continue unabated. One of these challenges is to increase joint purchasing of brand name drugs, which account for most pharmacy costs. To do this, the two departments need to address how differences in their respective patient populations, national formularies, and practice patterns among prescribers, some of whom are private physicians, can be managed to facilitate joint purchasing. Effectively doing so will be crucial for both VA and DoD to maintain control of their overall health care budgets.	10
GAO	GAO-06-905T	INFORMATION TECHNOLOGY: VA and DoD Face Challenges in Completing Key Efforts	June 22, 2006	VA and DoD are implementing limited, near-term demonstration projects, and they are making progress toward their long-term effort to share electronic patient health data. The two demonstration projects, which have been implemented at selected sites, have provided significant benefits, according to the two departments, because they enable lower costs and improved service to patients by saving time and avoiding errors: • Bidirectional Health Information Exchange, implemented at 16 sites, allows the two-way exchange of health information on shared patients in text format (including outpatient pharmacy data, drug and food allergy information, patient demographics, radiology results, and laboratory results).	xviii–xix
RAND	MG-154-OSD	Pharmacy Use and Costs in Employer-Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	To achieve savings without adverse health consequences, the drugs in a particular class should be easily substitutable and thus distinguishable principally on the basis of price.	xviii–xix
RAND	MG-154-OSD	Pharmacy Use and Costs in Employer-Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	The level of administrative restrictions and other financial incentives, such as those that encourage use of TMOP, will also impact the magnitude of savings.	xviii–xix

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING	PAGE
RAND	MG-154-OSD	Pharmacy Use and Costs in Employer-Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	The transition to the new program raises another important issue. The principal concern here regards the potential for adverse health effects when patients switch from an effective medication to a medication they have not used in the past. To achieve the significant cost savings suggested in this study without adversely impacting health, the DoD Pharmacy & Therapeutics Committee should carefully consider the drugs and drug classes that it places in the nonpreferred third tier. The most heavily scrutinized drugs should be those in the costliest therapeutic classes, which account for a disproportionate share of expenditures.	xviii–xix
RAND	MG-154-OSD	Pharmacy Use and Costs in Employer-Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	Recent growth in pharmacy spending has been largely due to the increased number of prescription drugs dispensed rather than to rising drug prices. If this trend continues, changes in benefit structures are likely to play a larger role in reducing the level of drug spending rather than in slowing the growth in expenditures.	xviii–xix
RAND	MG-154-OSD	Pharmacy Use and Costs in Employer-Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	TRICARE Management Activity (TMA) policymakers must also consider the critical question of whether lower pharmaceutical use resulting from higher patient cost-sharing adversely affects clinical outcomes and overall medical spending. Several previous studies support concerns about adverse effects. Other studies, by contrast, suggest that the effects of prescription drug cost containment policies are mostly benign. Our study found that adding a third tier did not reduce the probability of pharmacy use, but further study is needed to determine whether substitution from nonpreferred to preferred products resulted in adverse health outcomes.	xviii–xix
RAND	MG-237OSD	Determinants of Dispensing Location in the TRICARE Senior Pharmacy Program	2005	1) Although a majority of TRICARE Senior Pharmacy (TSRx) program prescriptions in FY02 were dispensed from MTF pharmacies, a majority of estimated ingredient costs were attributable to drugs dispensed from retail pharmacies. 2) Estimated ingredient costs could be reduced if dispensing shifted from retail pharmacies to dispensing locations where federal pricing is the basis of DoD's ingredient cost. 3) Geographic proximity to MTFs was strongly associated with TSRx use and utilization patterns. 4) Within two major therapeutic classes--antihyperlipidemics and gastrointestinals--the availability of a drug at an MTF was associated with increased use of the MTF and reduced use of retail pharmacies to fill other prescriptions.	xiv–xv
PUMA Systems, Inc.		Evaluation of Pharmacy Resource Allocation: Evaluating Best Business Practices and Commercial Technologies to Improve Delivery of Pharmaceutical Care in the Military Health System	16 Aug 2000	The recommendations are, in order of importance: 1) Consolidate MTF Refills at Regional Refill Centers; 2) Implement the Pharmaceutical Care Practice Model at Each MTF; 3) Develop DoD Guidelines and Criteria for Procurement of Automated Systems; 4) Study the Feasibility of a Joint Pharmacy Staffing Model; 5) Develop a New Approach to Adequately Fund DoD Pharmacy Operations; 6) Explore Pharmacy Outsourcing and Contracting Opportunities.	v–vii

Appendix E: Previous DoD Pharmacy Cost Control Measures

Mail Order Demonstration Project: 1994–1996

In order to achieve economies of scale in pharmaceutical purchases and to decrease overhead costs, DoD conducted a two-site demonstration project to evaluate the advantages/costs of a mail order pharmacy program as part of the DoD Pharmacy Benefit. The Logistics Management Institute conducted an evaluation of the project and determined this venue to be a cost-effective alternative and recommended expansion from two sites. This effort eventually evolved into the National Mail Order Pharmacy program.

National Mail Order Pharmacy Program (NMOP): 1997–2002

DoD decided to capitalize on the cost-effectiveness of the mail order pharmacy program. Although the TRICARE Managed Care Support Contractors (MCSCs) were providing a mail order pharmacy benefit, they could not access Federal Ceiling Prices (FCPs) for pharmaceuticals for which DoD believed it was entitled through the Veterans Health Care Act. Consequently, the TRICARE Management Activity (TMA) carved out the mail order benefit of the MCSCs and placed it under a single contract awarded and administered by the Defense Supply Center Philadelphia (DSCP). Through this contract, the DoD was able to access FCPs and achieve substantial savings on pharmaceuticals purchased and dispensed through the NMOP. Under this initiative, acquisition costs for medications approached that of the Military Treatment Facilities (MTFs).

Federal Ceiling Prices/Federal Supply Schedule: NMOP 1997

DoD can access favorable discounts for pharmaceutical purchases through the Federal Supply Schedule under the General Services Administration/Department of Veterans Affairs (VA) contracts and through the Veterans Health Care Act of 1992. These discounts of at least 24 percent off the nonfederal average manufacturer's price of drugs are accessible for pharmaceutical purchases in the MTFs and were implemented in the mail order program in 1997. Consequently, acquisition costs for medications in the mail order program approach those of the MTFs.

Pharmacy Benefit Redesign Project: 1998–1999

Section 703 of the Fiscal Year 1999 National Defense Authorization Act called for DoD to review the pharmacy benefit and to develop a systemwide redesign to include best business practices of the private sector, formulary management, and an integrated pharmacy information system. A workgroup consisting of DoD senior pharmacy leaders, private sector pharmacy benefit management consultants, resource management analysts, and statistical analysts conducted an extensive review and in 1999 submitted a report to Congress that included the following recommendations:

- Implement an integrated pharmacy information system to include military pharmacies, the mail order program, and TRICARE retail pharmacies. (This was realized in 2001 with the implementation of the Pharmacy Data Transaction Service.)
- Standardize policy implementation across all venues. (This was realized in 2004, when the retail benefit from the TRICARE Managed Care Contracts [MCSCs] was carved out and placed under DoD pharmacy program oversight.)

- Create tiered cost shares to provide financial incentives to influence beneficiary choice of lower-cost alternatives. (Two-tier was realized in April 2001; three-tier became effective May 2004.)
- Extend best federal pricing for pharmaceuticals to the retail pharmacy venue, comparable to that already available in the mail order program and military pharmacies. (This effort is ongoing.)
- Impose quantity limitations on certain drugs, require prior authorization for certain drugs, and require higher copayments for nonpreferred drugs. (This is in place.)
- Aggressively pursue third-party collections. (This effort is ongoing.)
- Create a centralized Pharmacy Benefits Office to oversee all DoD pharmacy programs. (This effort is ongoing.)

The redesign report also included recommendations that were not endorsed by DoD because of the perception of benefit erosion or extreme difficulties that would impede implementation:

- Impose copayments at military pharmacies, mirroring those in the mail and retail venues.
- Centralize funding for military pharmacies.

Many of the endorsed recommendations led directly to the efforts detailed below.

DoD Pharmacy Board of Directors: Chartered by Assistant Secretary of Defense (ASD) in 1997; rechartered biannually

Comprised of senior military pharmacists representing each of the Surgeons General, the board is a collaborative advisory body the work of which involves standardizing pharmacy operations policies, medication use, business process improvements, pharmacy management practices, and joint procurements. The board serves as a vital link between the ASD and military pharmacies.

Federal Pharmacy Executive Steering Committee (FPESC): Chartered 1998; rechartered biannually

Created jointly with the DoD Pharmacoeconomic Center and the VA Pharmacy Benefits Management Strategic Health Group, the FPESC was created to capitalize on the economies of scale between the two departments and to integrate and build on the strengths of pharmacy benefit management in each department. This forum provides the structure to jointly evaluate high-dollar and high-volume pharmaceuticals. It provides oversight to joint agency contracts and increases the clinical and economic outcomes of drug therapy in the DoD and VA health care systems. Ongoing DoD/VA joint pharmaceutical contracting initiatives continue to drive common formulary selections for both organizations. Cost avoidance for DoD through these joint procurements over the past seven years is illustrated as follows:

FY00	$65M
FY01	$78M
FY02	$139M
FY03	$148M
FY04	$185M
FY05	$211M
FY06	$423M

102

102 CAPT William Blanche, TMA. Information Paper: DoD Efforts to Control Pharmacy Benefit Costs Since 1994. January 4, 2007.

Mandatory Generic Policy: NMOP 1996; Retail 1999

Adopting a commercial business best practice, DoD implemented mandatory use of generics in the purchased care sector. A recent report states that the national generic utilization rate in large health plans is 43.5 percent. The average DoD generic utilization rate across all venues is 46 percent.[103]

Basic Core Formulary: 1999

The DoD Pharmacoeconomic Center analyzed, evaluated, and developed a list of drugs commonly used in all MTFs regardless of size or medical specialties offered and created the Basic Core Formulary. The DoD Pharmacy and Therapeutics Committee approved the list that increased DoD's leverage for obtaining favorable prices for these products. The list is routinely reviewed and updated by the committee as it reviews drug classes under the Uniform Formulary.

Pharmacy Resource Reallocation Project: 2000

The DoD Pharmacy Board of Directors and the TRICARE Management Activity Pharmacy Program Director tasked a tri-service workgroup consisting of pharmacists and pharmacy consultants to perform a detailed assessment of how DoD pharmacy resources (equipment, staffing, robotics, etc.) were allocated at the time and methods that could be implemented to reallocate those resources to maximize utilization. Because of changing demographics of the DoD beneficiary population, some pharmacies were over resourced and some under resourced. The result was a redistribution and standardization of pharmacy automation and a contract awarded for an enterprise-wide call-in refill system.

Advances in Medical Practice: 2000

The pharmacy portion of this limited funding provided money to purchase certain new, high-dollar drugs when they were indicated clinically but unavailable to small MTFs because of cost. In the past, these MTFs had no recourse but to send beneficiaries to the far more expensive retail pharmacies. Approximately $48 million was provided for these purchases, avoiding far greater costs than if the same drugs had been purchased in the retail sector.

Tiered Copays in Retail/Mail Order: 2001 and 2004

Adopting a commercial business best practice of using tiered copays to help influence beneficiary choice, DoD restructured and streamlined all pharmacy copays into two tiers based on generic and formulary with the implementation of TRICARE Senior Pharmacy in April 2001 and added a nonformulary third-tier with implementation of the Pharmacy Benefits Program Final Rule directed by 10 U.S.C. 1074g in May 2004.

Pharmacy Data Transaction Service (PDTS): Fully Implemented Worldwide 2001

The Pharmacy Data Transaction Service (PDTS) was created as part of DoD's effort to integrate the disparate pharmacy venues. It created a centralized data repository that records information about prescriptions filled for DoD beneficiaries at MTFs, the TRICARE retail pharmacy network, and the TRICARE Mail Order Pharmacy Program. The primary purpose of the PDTS is to improve the quality of prescription services and enhance patient safety by reducing the likelihood of adverse drug-drug interactions, therapeutic overlaps, duplicate treatments, and overuse of the benefit. Fully deployed since June 2001, it includes overseas MTF pharmacies and was a finalist for the President's Quality Award presented by President Bush in November 2002.

103 Ibid.

TRICARE Mail Order Pharmacy Program: 2003

The mail order pharmacy contract was recompeted and awarded to Express Scripts, Inc., on 26 September 2003.[104] At that time, contract oversight was moved from DSCP to TMA, resulting in a $20 million cost avoidance annually through lower administrative costs.

TRICARE Retail Pharmacy Program: 2004

In 2002, DoD decided to carve the retail pharmacy benefit out of the TRICARE MCSCs, allowing TMA pharmacy program oversight and improved management capabilities. The retail contract was awarded in September 2003, and service began in June 2004. The single national contract under one Pharmacy Benefits Manager consolidated the retail benefit from the previous multiple MCSC contracts into one management entity, providing a fully portable benefit unrestricted by regional boundaries and centralized pharmacy claims processing, which has reduced administrative fees by more than 70 percent per claim. The carve-out enabled the government to establish more favorable/guaranteed reimbursement rates for the network retail pharmacies. Outstanding performance by the contractor has resulted in further reductions in the reimbursement rate and increased cost avoidance to the government. The contractor has received the maximum monetary incentive award for these efforts. Secretary of Veterans Affairs Principi agreed that this new contract and organizational structure meets provisions of the Veterans Health Care Act of 1992 regarding favorable discounts for pharmaceutical purchases by DoD. DoD did pursue those discounts, which resulted in refunds to DoD that were stopped by the federal court in September 2006.

Pharmacy Commercial Off-the-Shelf (RxCOTS) Award: 2004

The RxCOTS award will streamline MTF business practices, improve the efficiency of third-party billing, and provide a perpetual inventory system that will promote tighter inventory control and accountability. RxCOTS will be implemented along with the worldwide deployment of the Armed Forces Health Longitudinal Technology Application.

Marketing Strategy for the TRICARE Mail Order Pharmacy (TMOP) Program: 2006

The TMA Marketing Office in conjunction with the Pharmaceutical Operations Directorate implemented a comprehensive TMOP marketing program in February 2006 and has since seen a steady increase in the use of TMOP.

---

104 See www.defenselink.mil/Releases/Release.aspx?ReleaseID=7014.

Enhanced Utilization Management: 2006

A division dedicated to utilization management was created under the Pharmaceutical Operations Directorate in May 2006. This team leverages the wealth of data from the Pharmacy Data Transaction Service, M2, and other Military Health Service data repositories to identify areas in which the delivery of the pharmacy benefit can be improved. The team analyzes current utilization trends and explores opportunities to utilize the most cost-effective points of service.

Federal Pricing Initiative for TRICARE Retail Pharmacy (TRRx): 2006

The pharmaceutical industry challenged in federal court the legality of the government's request to receive refunds from the pharmaceutical industry for products dispensed through the TRICARE retail network. The department lost the lawsuit.

Proposed Legislation for TRRx Federal Pricing: 2006

Congress did not pass the proposed legislation.

Increasing Pharmacy Beneficiary Cost Shares: 2006

Efforts to increase pharmacy copayments, including proposed legislation to relieve the maximum cap of 20 to 25 percent currently imposed and to structure the copayments to incentivize use of the TMOP, were rejected by Congress, which has placed a freeze on increasing copayments until October 2007.

Implementation of Voluntary Agreements for TRICARE Retail Pharmacy Rebates: 2006

In December 2006, TMA notified more than 300 manufacturers of a new initiative called "Voluntary Agreements for TRICARE Retail Pharmacy Rebates" (VARR). The VARR is a new program through which manufacturers can voluntarily offer rebates on certain products based on Uniform Formulary placement or DoD utilization over time. The manufacturers are under no legal or contractual obligation to do so; however, many senior industry representatives have indicated that many manufacturers will participate to some degree.

Appendix F: Task Force Staff

Colonel Christine Bader
United States Air Force, Nurse Corps
Executive Secretary

Lieutenant Colonel Brian E. King
United States Air Force, Medical Service Corps
Department of Defense Senior Research Analyst

Lieutenant Colonel Janice F. Nickie-Green
United States Army, Nurse Corps
Department of Defense Senior Research Analyst

Commander Leslie Moore
United States Navy, Medical Service Corps
Department of Defense Senior Research Analyst

Lieutenant Colonel Nanette S. Patton
United States Army, Medical Service
Department of Defense Senior Research Analyst

Lieutenant Commander Waldo F. Ferreras
United States Navy, Medical Service Corps
Department of Defense Senior Research Analyst

Major Vito S. Smyth
United States Air Force, Medical Service Corps
Department of Defense Senior Research Analyst

Thomas Abbey
Staff Director

Betsy L. Freeman
Director, Program Services

Jillian R. Fox
Knowledge Manager

A. Sheritta Cooper Porter
Logistics Support Manager

Kathi E. Hanna, Ph.D.
Lead Writer

Sara Davidson Maddox
Editor

Other Contributors:

Pittny Creative, LLC
Design

Colorcraft of Virginia, Inc.
Printing